University of Alberta

A Window into Therapy:
The Therapeutic Relationship with Survivors of Childhood Sexual Abuse

by

Mary Elizabeth Pudmoreff ©

A thesis submitted to the Faculty of Graduate Studies and Research in partial fulfilment
of the requirements for the degree of Master of Education

in

Counselling Psychology
Department of Educational Psychology

Edmonton, Alberta
Spring, 1997

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Dedication

First and foremost, I dedicate this thesis to my wonderful husband, Darrell Pudmoreff. Darrell, thank-you for your continual support, your ongoing encouragement, your helpful comments, and your unending patience. If I were to list all the ways in which you helped me through this process, the length of my thesis would double. Instead, let me say, thank-you and I love you more and more and more and more each and every day.

Secondly, I dedicate this thesis to a remarkable woman with whom I have developed a cherished relationship: Karen Goldstone. Karen, I have an incredible amount of respect for you. I hope that one day I am able to touch the lives of my clients to the same degree that you have touched my life. Thank-you for all that you have given, for all that you have shared. You are amazing.

Thirdly, I dedicate this thesis to two people who are very dear to me, my sisters, Hannah and Elizabeth Konkin. Hannah and Elizabeth, it feels as though we have been robbed of many years of special memories, but I want you to know, you are both very special to me and you are always in my thoughts and prayers. I love you both very much and I hope one day we will be able to share our lives with one another.

Fourthly, I dedicate this thesis to my father, Anthony Smoch. Dad, you have shown great courage in your battle against cancer. When you were diagnosed, I did not think that you would be alive to share my joy when I completed my thesis. I am grateful that you are here to celebrate with me. Your determination is inspiring. I love you.

And finally, I dedicate this thesis to survivors of childhood sexual abuse and to their therapists with the hope that it will provide additional understanding about what constitutes effective therapy. And, for survivors who are struggling as they heal I would like to share one client's encouraging comments: "You can get through it. You can survive, thrive and be at peace with it. Surprisingly enough. You can. I truly believe that because I know. You can."

Abstract

This study explored clients' and therapists' perceptions of the experience of therapy when successfully treating childhood sexual abuse. An existential or hermeneutical phenomenological research approach was utilized to gather descriptions from three client-therapist dyads who had been engaged in long-term therapy.

The findings of this study emphasized the pivotal role that the therapeutic relationship has in contributing to effective therapy. The participants' interview data resulted in a framework describing the experience of being in therapy for the treatment of childhood sexual abuse. This framework consisted of five components: the healing foundation, the building blocks, the threads that bind, the healing that occurs through relationship, and the rewards of the experience. Although many of the components identified by clients and therapists were similar, there were significant differences. Clients identified therapist availability and containment/closure as important whereas therapists emphasized rediscovering the client's voice and maintaining therapist integrity. Empathic generalizability, assessed by sharing a summary of the findings with other clients and therapists, suggested that the framework proposed is reflective of the experiences of clients and therapists beyond those who had participated in this study.

Acknowledgements

Without the support and assistance of many people, this thesis would not have been possible. Thank-you to the clients and therapists who gave so generously of themselves by sharing their experiences with me so that I could share them with others. Thank-you to Barbara Paulson for her support, encouragement, understanding, and constructive comments throughout this project. Also, thank-you to Don Sawatzky and Susan Scott for their helpful feedback and support.

Behind the scenes, there are also many people who deserve acknowledgement. Thank-you to Betty-Lou Sheppard and Christina Smoch for their generous assistance in transcribing the interviews. Thank-you to Andrea Meiklejohn and Darolyn Burden for their helpful comments regarding the data analysis. Thank-you to Joanna Bolster for being a sounding board and offering creative assistance during the final stages of this project. Thank-you to the six clients and six therapists who reviewed my final summary and offered their reflections. And, once again, thank-you to my husband, Darrell, for everything!

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Chapter 1: Introduction

Significance of this Study

Every day we are inundated by reports of childhood sexual abuse in the media. Being sexually abused in childhood can have many long-term effects including symptoms of post-traumatic stress; depression; somatization; dissociation; interpersonal dysfunction; eating disorders; sexual dysfunction; sleep disturbances; self-mutilation; and, suicidality (Alter-Reid, Gibbs, Lachenmeyer, Sigal, & Massoth, 1986; Blume, 1990; Briere, 1992; Browne & Finkelhor, 1986; Cahill, Llewelyn, & Pearson, 1991a; Courtois, 1988; Suffridge, 1991; Waites, 1993). Finkelhor, Hotaling, Lewis and Smith (1990) found that 27% of women and 16% of men surveyed had a history of sexual abuse. Given the alarming frequency of childhood sexual abuse and its wide ranging effects, it can be expected that every mental health clinician will, at some time, work with adult survivors of sexual abuse (Cahill Llewelyn, & Pearson, 1991b; Feinauer, 1989; Suffridge, 1991). Although many people recover without therapy, mental health professionals agree that in many instances, if the effects of having been sexually abused in childhood are to be successfully resolved, therapy is needed (Feinauer, 1989).

For many years, efforts have been made to understand whether what therapists do leads to change and to discover what it is that they do that is helpful. There is a substantial body of evidence that indicates psychotherapy is effective; however, research has also suggested there is relatively little difference in outcomes secured when different forms of psychotherapy have been compared (Elkin et al., 1989; Garfield, 1990; Gelso & Carter, 1985, 1994; Greenberg, 1986; Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Lambert, Shapiro & Bergin, 1986; Miller, Hubble, & Duncan, 1995; Stiles, Shapiro, & Elliott, 1986; Strupp, 1982; Walborn, 1996).

Most of the studies regarding the effectiveness of therapy have focused on relatively short-term counselling with presenting problems such as anxiety, depression, academic concerns, or career indecision (Elkin et al., 1989; Hill, 1990; Llewelyn, Elliott, Shapiro, Hardy, & Firth-Cozens, 1988; Martin & Stelmaczonek, 1988). An extensive study examining the effectiveness of two brief psychotherapies in the treatment of depression suggested that, although there were not significant differences between the effectiveness of each approach, overall psychotherapy appears to be useful (Elkin et al., 1989). This study suggests that all forms of psychotherapy result in roughly the same degree of effectiveness, regardless of the theoretical approach or orientation of the therapist. Although psychotherapy produces change, it is unclear what contributes to an effective therapeutic experience.

Since different therapy approaches result in roughly the same degree of effectiveness, researchers have proposed that common factors between approaches may be accounting for the effectiveness of psychotherapy. Some of the common factors that have been examined include: empathy, warmth, and genuineness (Patterson, 1984); a working alliance, a transference configuration, and a real relationship (Gelso & Carter, 1985, 1994); and, therapeutic technique, expectancy and placebo, therapeutic relationship, and client factors (Miller et al., 1995).

While there has been considerable research on the effectiveness of therapy, a limited amount of this research has incorporated client perceptions of what makes therapy effective. Hill and Alexander (1993) contend that the dearth of literature offering wisdom and guidelines for treating sexual abuse survivors is based mainly on clinicians' "subjective judgments about what works in treatment" (p. 415) and that these judgments may be based on things such as limited client populations, expectations, countertransference, and selective distortion. In addition, it was argued that "therapists may also have different experiences of what is helpful than do their clients" (Hill & Alexander, 1993, p. 415).

Further support for the necessity of including the client's perception in research comes from a literature review focused on varieties of client experiences in therapy. A review by Elliott and James (1989) indicated that the client perspective is the most direct source of information about the client's experience since it allows access to information such as unexpressed reactions, meanings, and links between experiences. Elliott and James concluded that, "client perceptions of the therapeutic relationship or therapist style of relating (e.g., empathy) have been shown to predict outcome, often better than ratings by observers or therapists" (Elliott & James, 1989, p. 445). Also, Orlinsky and Howard (1967) emphasized the value of client perceptions when they stated, "Insofar as patients and therapists are the working 'grass roots' experts on psychotherapy, their conception of the good therapy hour may be instructive" (p. 629). Remarkably little has been done to include the voice or perspective of clients when investigating mental health services for survivors of childhood sexual abuse (Hutchinson & McDaniel, 1987).

Purpose of the Study

The aim of this research project is to increase our understanding of therapy with childhood sexual abuse survivors by including both participants who have had long-term counselling and the therapists who have treated them. The questions guiding this research include:

1) From the perspectives of both therapists and clients, what contributed to an effective therapeutic experience?

2) For each therapist-client dyad, how do the perspectives compare?

Through an existential phenomenological approach, the experience of treatment for adults with a history of repeated, intrafamilial childhood sexual abuse was explored from the perspectives of both clients and therapists who have worked together in long-term relationships. In this way, this study aims to provide a deeper understanding of the therapy experience of childhood sexual abuse.

Chapter 2: Literature Review

Introduction

An important step before beginning this research involved examining existing literature regarding adult survivors of childhood sexual abuse and the experience of therapy. First, an understanding of the problem of childhood sexual abuse is gained through a brief overview of the research regarding its prevalence, effects and treatment. Secondly, research regarding the helpful and hindering aspects of therapy with survivors of childhood sexual abuse is examined. Thirdly, studies on psychotherapy outcome are reviewed. Fourthly, research which has explored the degree of congruence between clients' and therapists' perceptions is considered. And finally, the implications of the existing literature for this study are discussed.

Prevalence Studies of Childhood Sexual Abuse

It is difficult to determine the prevalence of childhood sexual abuse since statistics regarding sexual abuse vary considerably depending on several methodological issues including how sexual abuse is defined, sample size and characteristics, and data collection techniques. In addition, research regarding the prevalence of childhood sexual abuse depends on the respondent's cooperation and willingness to disclose information, the reliability of the respondent's memory, and the thoroughness of professionals to document and report abuse (Hopper, 1996; Peters, Wyatt, & Finkelhor, 1986). There is, however, an even bigger obstacle to estimating the prevalence of childhood sexual abuse and that is secrecy. Due to the shame surrounding sexual abuse, many cases go unreported, particularly when the offender is a family member (Alter-Reid et al., 1986). For these reasons, the actual incidence of childhood sexual abuse is unknown. Estimates of its prevalence range from 6 percent to 62 percent for females and from 3 percent to 31 percent for males (Peters et al., 1986). However, due to the difficulties inherent in researching the prevalence of sexual abuse, many researchers consider these estimates to be conservative (Alter-Reid et al., 1986; Finkelhor, 1990; Russell, 1983).

Russell (1983) used trained female interviewers and a standardized interview schedule to conduct in-depth interviews with a randomly selected sample of 930 adult women in San Francisco. Results revealed that 38% of the women surveyed had at least one unwanted sexual experience involving actual physical contact with an adult prior to the age of 18 and that 28% had one such experience prior to the age of 14. In addition, results indicated that only 8% of these cases were ever reported to the police and that the overwhelming majority of perpetrators were known to their victims. When sexual abuse not involving physical contact was considered, such as the offender exposing himself, over half of the subjects reported that they had been victimized.

In a review of the empirical findings of research regarding the sexual abuse of children, Alter-Reid et al. (1986) suggested that child sexual abuse cases reported to professionals may represent only one fourth of actual cases of abuse. This review indicated that there are 4 to 5 times as many female victims as male victims and that, in the majority of cases, the perpetrators are known to the victims. It concluded that sexual abuse is not limited by racial, ethnic, or economic boundaries. Alter-Reid et al. stated that since only a fraction of the actual cases of childhood sexual abuse are brought to the attention of professionals, adult retrospective reports are likely more representative of the true incidence of childhood sexual abuse. The retrospective survey reports reviewed by Alter-Reid et al. suggested that the incidence of childhood sexual abuse ranges from 19% (one fifth) to 54% (one half) of women. The authors indicated that 38% seemed to be the most accurate estimate since it reflected data with the most stringent definitions of abuse and was based on a random sample of women. It was pointed out, however, that even this may be an underestimate since many women may be reluctant to disclose a history of sexual abuse or may have repressed any recollection of early abuse.

In the first national prevalence study of sexual abuse, Finkelhor et al. (1990) found that 27% of the women and 16% of the men surveyed had a history of sexual abuse. In this study, the definition of "sexual abuse" focused on the subjects' perceptions of what was sexually abusive and included questions regarding activities such as nude photography, exhibitionism, witnessing sex acts, touching, kissing, oral sex and/or intercourse. The subjects for this survey were randomly selected from a list of people with residential telephones throughout the United States of America. In total 1,145 men and 1,481 women were questioned for approximately a half hour on topics related to sexual abuse. Finkelhor et al. cautioned that the findings from this study cannot be relied on alone since some problems with methodology existed (e.g., the questions asked were very open and depended on subjects' perceptions). However, this national survey did confirm much of what had been discovered in previous studies completed at the regional level.

Effects of Childhood Sexual Abuse

Although it is difficult to obtain accurate data regarding the actual incidence of childhood sexual abuse, it is clear that hundreds of thousands of children are being sexually assaulted each year (Alter-Reid et al., 1986). Considerable research has explored how being sexually abused as a child affects later functioning as an adult.

After reviewing the literature regarding the impact of child sexual abuse, Browne and Finkelhor (1986) concluded that empirical studies have indicated that reactions occurring within two years of the termination of abuse include fear, anxiety, depression, anger and hostility, aggression, and sexually inappropriate behaviour. In addition, long-term effects seem to include depression and self-destructive behaviour, anxiety, feelings of isolation and stigma, poor self-esteem, difficulty parenting, difficulty trusting others, a tendency toward revictimization, substance abuse, and sexual maladjustment. Browne and Finkelhor argued, "as evidence now accumulates, it conveys a clear suggestion that sexual abuse is a serious mental health problem, consistently associated with very disturbing subsequent problems in some important portions of its victims" (p. 72).

Cahill et al. (1991a) also examined the literature regarding the long-term effects of sexual abuse which occurred in childhood. These authors reached conclusions similar to those of Browne and Finkelhor (1986) and loosely categorized the effects into four areas: emotional reactions, self-perceptions, relationship problems, and problems with sexuality. Additionally, this research suggests that survivors of childhood abuse are prone to revictimization and other problems reported by survivors including somatic complaints, obsessive/compulsive behaviour, eating disorders, suicidal tendencies, self-injurious behaviour and psychotic episodes. In their review of the literature, Cahill et al.

included the limited information available regarding the effects of childhood sexual abuse on male victims which indicated that men experience similar effects to women including depression, isolation, poor self-concept, self-blame, difficulty in establishing and maintaining relationships, and sexual problems.

After analyzing existing literature, Browne and Finkelhor (1986) concluded that the kinds of abuse that appear to be most damaging are experiences involving father figures, genital contact, and force. Evidence of the influence of factors such as age of onset and frequency and duration of the abuse is inconclusive (Cahill et al., 1991a). However, Mullen (1993) contends that the impact of childhood sexual abuse will vary, not only according to the severity of the abuse, but also according to the phase in the child's development when it occurs and the resilience of the child to whom it occurs. Other researchers emphasize the age of onset and the number of developmental transitions during which the abuse persisted (Cole & Putnam, 1992). Alter-Reid et al. (1986), Browne and Finkelhor and Cahill et al. have indicated that a supportive response at the time of disclosure will help to reduce the long term effects of childhood sexual abuse.

Does this mean all children who have been sexually abused will exhibit these long-term effects? The answer is no. One study, based on a random sample survey of women who had been the victims of childhood sexual abuse, suggested that 26% of respondents felt the abuse had a "great" effect, 26% reported "some" effect, 27% indicated "little" effect and 22% reported "none" (Cahill et al., 1991a). The researchers found that 54% of both men and women abused as children reported a damaging effect on their lives. When the abuse was intra-familial the percentage increased to 67% and when the abuser was a parental figure, the figure rose to 75% reporting a damaging effect (Cahill et al., 1991a). Although the long-term effects are not inevitable, the risk of mental health impairment for victims of child sexual abuse should be taken very seriously (Browne & Finkelhor, 1986). Perhaps Mullen (1993) said it best: "Abuse is not destiny, but it does make progress toward successful social, interpersonal, and intrapsychic functioning in adult life more difficult" (p. 431).

Treatment of Childhood Sexual Abuse Survivors

It is likely that every mental health clinician will at some time work with adult survivors of sexual abuse--whether they know it or not (Cahill et al., 1991b; Feinauer, 1989; Suffridge, 1991). Research based on clinical samples has indicated that women who have experienced childhood sexual abuse constitute a significant percentage--as much as 40%--of women seeking therapy, although the abuse may not be the presenting complaint (Gordon & Alexander, 1993). Other studies have suggested that psychotherapists can expect that a minimum of one-third, and possibly as much as two-thirds, of their clients will have experienced either physical or sexual abuse or both (Suffridge, 1991). Furthermore, in low-fee clinics, substance abuse treatment centres, and inpatient psychiatric units, the proportion of survivors of childhood physical or sexual abuse may approach 100% (Suffridge, 1991).

Feinauer (1989) studied a sample of 57 nonclinical adult women who had been sexually abused as children. Of the 57 subjects who responded to the advertisement, 36 women had received therapy and 21 had not attended therapy. Results indicated that 20 of the 36 women who received therapy reported that they were successfully able to resolve the issues related to their sexual abuse. Feinauer reported that of the 57 subjects who were sexually abused, 36% believed they had successfully adjusted to the trauma of their sexual abuse without therapy, 36% reported they improved after therapy, and 28% believed they had not changed as a result of therapy. Feinauer cautioned that the successful adjustment reports seemed optimistic since 89% of the subjects reported that they felt they still needed help in resolving issues they perceived to be related to their abuse--including sex therapy (35.7%), individual issues (19.6%), marital therapy (5.4%), and family therapy (1.8%). The researcher explained that the discrepancy between high reports of adjustment while 89% of the subjects still identified high reports of needing more therapy may have occurred because the concepts of "adjustment to" and "resolution of" childhood sexual abuse may be very different. Other results in this study indicated that there was no relationship between the amount of time in therapy and perception of successful therapy or subsequent adjustment. In addition, the quality of the support system seemed to influence the level of the subjects' adjustment to the trauma of sexual abuse.

Regardless of theoretical orientation or counselling approach, most therapists believe that resolving the trauma of sexual abuse, particularly incest, requires long-term treatment (Feinauer, 1989). If the effects of having been sexually abused in childhood are to be successfully resolved, mental health professionals agree that in most cases, therapy is needed (Feinauer, 1989). In addition, there seems to be consensus within the clinical literature that adult survivors of childhood sexual abuse do not form a homogeneous group. Each client enters therapy with different issues, concerns, and problems. Thus, regardless of the theoretical orientation, treatment should be tailored to meet the particular needs of individual clients (Cahill et al., 1991b; Courtois, 1988; Roth & Newman, 1993).

Helpful and Hindering Aspects of Therapy with Survivors

A study by Armsworth (1989) offered general guidance for clinicians who treat adult survivors of incest as to what clients deem helpful and what they deem not helpful or hindering. In this study, 30 adult female incest survivors rated the helpfulness of counselling services received. The subjects had utilized 113 professionals and had spent an average of 36 sessions in helping relationships (i.e., nine months). Results of this study indicated that, clients considered four categories of interventions helpful: 1) validation; 2) advocacy; 3) empathic understanding; and, 4) absence of contempt, punishment, or derision. In addition, four practices or conditions were considered least helpful or even harmful: 1) lack of validation of the client's experience; 2) blaming the victim; 3) negative, rejecting or absent responses from the therapist; and 4) exploitation or victimization of the client.

Carver, Stalker, Stewart and Abraham (1989) reported on the effectiveness of group therapy for 95 female adult survivors of childhood sexual abuse who were referred to an outpatient psychiatry clinic. The groups varied in length from 10 to 15 weeks and part of the data collected included subjective reports from participants in the form of group termination evaluation questionnaires. On the subjective evaluation questionnaires, the women indicated substantial satisfaction with the group. Half of the women who completed the questionnaires considered the group to have been considerably helpful and approximately one third felt it was moderately helpful. The aspects of the group most consistently described as helpful included being able to share with others, feeling understood, learning they were not alone, realizing they were not as different as they thought, and being able to talk openly about the abuse.

Bonney, Randall, and Cleveland (1986) examined factors regarded as most and least therapeutic by members of a therapy group of seven women who experienced childhood incest. In this study, therapists' perceptions were also examined. Clients completed a Q-sort according to what factors they believed were most and least helpful while therapists sorted items according to what they believed to be the most important experiences for each client. Items that therapists believed were helpful to clients, such as self-understanding and altruism, were not items that clients felt were helpful. Therapists saw growth where the clients felt pain and, as a result, therapists perceived the clients to be more advanced than the clients perceived themselves to be. One of the conclusions that Bonney et al. made from this study was that therapists view their clients' therapeutic process and progress differently than do clients.

Wheeler, O'Malley, Waldo, Murphey and Blank (1992) utilized the Q-sort to assess member perception of therapeutic factors as seven women in an incest survivor group looked back at the total group experience. The researchers assessed potential changes in member perceived therapeutic factors over the life of the group by having members respond to the question, "What event (incident, interaction) from this session was most helpful to you? Describe what happened, the feelings you experienced and how the event was helpful to you" (Wheeler et al., 1992, p. 91). These statements of critical incidents were then classified into therapeutic factors. The results of the Q-sort in this study indicated that the women believed the most therapeutic factors were catharsis, self-understanding, the existential factor or learning to take ultimate responsibility for one's life, and cohesiveness, in that order. An analysis of the information gathered through critical incidences suggested that the factors that were most often found helpful included self-understanding, vicarious learning, acceptance, and self-disclosure.

Research on Psychotherapy Outcome Studies

Since there is limited research specifically examining therapy with survivors of sexual abuse, research regarding clients with other presenting concerns can be examined in order to learn more about what is helpful in therapy. A collaborative study by the National Institute of Mental Health investigated the effectiveness of two specific forms of psychotherapy, cognitive behaviour therapy and interpersonal psychotherapy, in the treatment of nonbipolar, nonpsychotic depressed outpatients (Elkin et al., 1989). This study also involved two groups receiving clinical management and either a drug commonly used to treat depression or a placebo. This extensive study, which involved 250 clients who were randomly assigned to the four treatment groups, was the first head-to-head comparison of two psychotherapies that had previously proven effective with depression (Elkin et al., 1989; Elkin, 1994).

Results from this collaborative study on depression indicated that there was "no evidence of greater effectiveness of one of the psychotherapies as compared with the other...[and]...All treatment conditions...evidenced significant change from pretreatment to posttreatment" (Elkin et al., 1989, p. 980). Since a group of clients who were less severely depressed and who were receiving case management and a placebo showed improvement, it was suggested that "minimal supportive therapy and expectations regarding the medication, along with the generally supportive research and treatment environment, may be sufficient for many patients to achieve a significant reduction in depressive symptoms and improvement in general functioning" (Elkin et al., 1989). Thus, this research suggested that, although there were not significant differences between the effectiveness of each approach, overall psychotherapy appears to be useful. This study suggested the effectiveness of psychotherapy was influenced by common factors in different types of treatment. An additional finding of this study is that a relatively small percentage of patients remain in treatment, fully recover, and remain completely well throughout the 18 month follow-up period (Elkin, 1994). The researchers concluded that, although the treatments examined were helpful to many people, investigations need to also focus on alternatives such as longer periods of initial treatment, periodic maintenance session, and combining various treatment approaches (Elkin, 1994).

Using meta-analytic procedures, Horvath and Symonds (1991) explored whether the quality of the working alliance was related to therapy outcome. The studies included in this review all involved experienced therapists working in clinically valid settings. The authors concluded that therapy involving a good working alliance between client and therapist is more likely to succeed and that, while various definitions of this alliance or relationship are used, all of the definitions seem to involve the concepts of collaboration, mutuality, and engagement. In addition, the authors reported that, while the quality of the working alliance is an important factor in therapy outcome, there is considerable disagreement about how the alliance operates and what contributions each of the participants makes to its development.

Elliott and James (1989) conducted a comprehensive analysis of the literature regarding varieties of client experiences in therapy. In this review, it was noted that with regard to specific therapeutic effects of individual therapy, clients seem to perceive two main types of impact: Task/Problem Solving impacts which influence the accomplishment of tasks related to client presenting problems and central concerns, and Interpersonal/Affective impacts which occur when the client experiences help or relief directly through the medium of the relationship with the therapist. The most common Task/Problem Solving impact identified was self-understanding or insight while the most common Interpersonal/Affective impacts were expression or catharsis and reassurance or confidence. Elliott and James also concluded that clients perceive the effective ingredients of therapy to include facilitative therapist characteristics, client unburdening, self-understanding, and perceived therapist encouragement for gradual practice.

Another study examining helpful and hindering processes in therapy was that by Lietaer (1992) in which 25 therapists and 41 clients completed post-session evaluations. Results of this study indicated that, although there were some differences in emphasis, both clients and therapists perceived self-exploration and experiential insight as the salient ingredients of their therapy sessions. The most helpful interventions identified included exploratory questions, restatement of content, and reflection of feeling. Other helpful processes included specific techniques, therapist self-disclosure, confrontation, interpretation, feedback, reinforcement and advice giving. With regard to hindering processes, clients' and therapists' descriptions often had the flavour of missed opportunities or transitory moments that were experienced as difficult in an otherwise positive session. Overall, it seemed that clients were more lenient in their judgment than therapists.

Elliott (1985) developed an empirical taxonomy for helpful and nonhelpful counselling events based on clients' descriptions of immediate therapeutic impact. Cluster analysis identified eight kinds of helpful events that fell into two main aspects of helping interactions: task and interpersonal. In the cluster or group related to task, the predominant helpful event was "new perspective" and in the group related to interpersonal aspects, the predominant cluster was "understanding". In addition, kinds of nonhelpful events were identified, the most common being "misperception", "negative counsellor reaction", and "unwanted responsibility".

Murphy, Cramer and Lillie (1984) conducted a study which examined the relationship between curative factors as perceived by clients and treatment outcome. Twenty-four out-patients at various stages of recovery were asked what factors they believed had helped them in their treatment and were subsequently asked to rate a predesigned list of factors in terms of helpfulness. Therapists and clients were asked to complete scales which assessed client improvement since therapy started. Results suggested that two factors which clients perceived as being of therapeutic help are talking to someone who understands and receiving advice. Both of these factors were positively and moderately related to outcome. The researchers concluded that the results of this study indicated that it may be more effective to investigate the role of factors such as the advice and understanding given by the therapist in bringing about therapeutic change, rather than assessing the influence of differences in therapeutic techniques.

Hill et al. (1988) examined therapist response modes in relation to pretreatment symptomatology, immediate outcome, session outcome, and treatment outcome. In addition, therapist response modes were considered in conjunction with therapist intentions and client experiencing. Participants in the study included eight women who were anxious and/or depressed and eight experienced therapists from a variety of settings. Therapist response modes considered included approval, information, direct guidance, closed question, open question, paraphrase, interpretation, confrontation, and self-disclosure. Results indicated that response modes were related to all immediate outcome measures--therapist and client helpfulness ratings, client experiencing, and client reactions. Self-disclosure, interpretation, approval and paraphrase were identified as the most helpful response modes. It also seemed that the effectiveness of therapist interventions depended on the previous client experiencing level, suggesting that context and timing are important variables in the psychotherapy process.

Another way to examine what is helpful or not helpful in the therapeutic process is to consider the impact of significant events that occur during therapy. A study by Llewelyn et al., (1988) compared the impact of helpful and hindering events as perceived by 40 clients in two different types of individual therapy--cognitive/behavioral and psychodynamic/verbal. The results of this study indicated that during treatment the most common helpful impacts for clients were problem solution, awareness, and reassurance; the most common hindering impact for clients was unwanted thoughts.

A study by Martin and Stelmaczonek (1988) involving three counsellor-client dyads examined client identification of significant events and their ability to recall events previously identified as important. The results of this research demonstrated that events in counselling that clients identified as important contained dialogue indicative of deeper, more elaborative, and more conclusion-oriented information processing. In addition, this study indicated that, in a six month follow-up, clients were able to recall previously identified important events with considerable accuracy.

Congruence of Client and Therapist Perceptions

Although the vast majority of research regarding treating sexual abuse survivors is based on therapists' views on what is helpful (Hill & Alexander, 1993), it is important to also examine the literature regarding the congruence between therapists' and clients' perceptions. Dill-Standiford, Stiles, and Rorer (1988) studied 296 counselling sessions that involved a total of 42 clients and 12 counsellors to compare clients' and therapists' perspectives on session impact. After each counselling session, each participant was asked to complete two Session Evaluation Questionnaires (SEQ) regarding session characteristics and post-session mood. The first questionnaire focused on one's own perceptions or feelings and the second one asked about how one thought the other person would respond. For example, the client indicated how he/she believed the counsellor felt about the session. Dill-Standiford et al. concluded that "counsellors and clients appear to have distinctly different viewpoints on counselling; researchers should assess both views" (p. 54).

In an investigation of the extent to which clients and therapists agree on their perceptions of individual therapist intention and impact, Caskey, Barker, and Elliott (1984) studied 16 pairs of clients and therapists who were recruited from a variety of out-patient settings. Segments of actual sessions were audiotaped and participants were asked to describe the therapists' intentions during the selected segments of the sessions in which they had been involved. Results suggested that "discrepancies between client and therapist perceptions are an important and commonplace occurrence" (p. 287). Clients generally reported more positive impact for their therapists' responses than did their therapists. The variables of duration of relationship and therapist experience level appeared to bear little relationship to client-therapist agreement. Caskey et al. suggested that the low response-level agreement indicated that therapists had little awareness of the immediate impact of their responses and noted that this was consistent with frequent observations of experienced therapists who have recognized that seemingly off-hand remarks are sometimes experienced as more helpful than deeply empathic reflections or carefully formulated interpretations. The researchers concluded, "therapists need to be cautious in assuming the accuracy of their perceptions of their clients' thoughts and feelings, and also be alert to client misperceptions of the therapeutic process" (p. 289).

Fuller and Hill (1985) examined counsellor and client perceptions of counsellor intentions in relation to outcome in a single counselling session. Four experienced therapists each saw four clients for a single counselling session. Counsellors and clients evaluated the sessions and then participated in a tape-assisted review of the sessions during which the participants identified counsellor intentions and rated the helpfulness of each intention. The results of this study indicated that after participating in the same counselling session, counsellors and clients perceived different things to have occurred. Clients felt that counsellors were using more support, focusing, and clarifying and less self-control and resistance than the counsellors felt they were using. Clients found some intentions such as therapist needs, resistance, cognitions, relationship, insight, and challenging to be more helpful and other intentions such as setting limits, getting information, supporting, and focusing were found to be not as helpful.

In the study by Fuller and Hill (1985), it seemed that the less helpful intentions occurred more at the beginning of the session whereas the helpful ones tended to occur later in the session. In addition, therapists felt the sessions were deeper when they intended to help clients cathart, attended to their own needs, worked toward insight, and helped clients focus; clients, on the other hand, gave deeper ratings when they perceived that the counsellor was trying to help them internalize and reinforce change. Another interesting difference was regarding client and therapist views of the smoothness of sessions. Therapists identified smooth sessions as ones in which they could get the problems solved easily. Clients, on the other hand, considered smoother sessions to be the ones in which they received reassurance.

In a study conducted by Thompson and Hill (1991) therapist perceptions of client reactions were examined. Sixteen therapists each saw two volunteer clients for single counselling sessions. After each session, therapists rated the helpfulness of each intervention and indicated their perceptions of the client reaction to each intervention. Clients considered each intervention and rated its helpfulness and indicated their reaction to it. Results indicated that in 50% of the instances therapists reported the same reaction cluster as the clients did. Challenged and negative reactions proved more difficult for therapists to recognize (i.e., match rates of 27% and 14% respectively). In addition, the results suggested that therapists' ability to match client reactions was related to the therapists' ability to generate helpful interventions.

Another way to explore the process of therapy and the degree of congruence between counsellor and client perceptions is to examine counsellor and client identification and recall of important or significant events in counselling. Significant events in therapy are portions of therapy sessions in which clients experience a meaningful degree of change or help. Martin and Stelmaczonek (1988) conducted such a study. Results indicated that counsellors and clients tended to identify as important those events that involved expressions of insight and understanding, provisions of personal material, description and exploration of feelings, and expressions of new ways of being or behaving. In this study, three experienced counsellors were matched with eight clients who were university students in order to form eight counselling dyads. After two or three sessions at different stages of therapy, participants were asked structured questions such as "What were the most important things that happened during this session?" (Martin & Stelmaczonek, 1988, p. 386). Counsellors and clients tended to identify the same general categories of important events. In addition, counsellors and clients identified exactly the same event as important in roughly one third of the cases in which they reported important events (Martin & Stelmaczonek, 1988).

Hill, Mahalik, and Thompson (1989) studied client and therapist perceptions of the use of self-disclosure by therapists in eight cases of brief psychotherapy with anxious or depressed clients and experienced therapists. Each self-disclosure was rated by judges on two dimensions that were mutually exclusive: involving/disclosing and reassuring/challenging. Involving disclosures were present tense disclosures which expressed the therapist's feelings or cognitions regarding the client and/or therapy and disclosing ones revealed something about the therapist or therapist's life that does not directly involve the client or therapy. Reassuring disclosures were ones in which the therapist supports, reinforces, or legitimizes the client's perspective, way of thinking, feeling, or behaving. Challenging disclosures confronted the client's perspective, way of thinking, or behaving. After each session, clients and therapists watched a videotape of the session and both participants rated the helpfulness of the therapist intervention.

The results of this study by Hill et al. (1989) indicated that reassuring disclosures were rated as more helpful by both clients and therapists and led to higher levels of client experiencing than did challenging disclosures. There did not appear to be any difference in helpfulness between disclosures which expressed the therapist's feelings or thoughts about the client or about therapy (i.e., involving disclosures) and those disclosures which revealed something about the therapist not directly related to the client (i.e., disclosing disclosures). The results also suggested that, in general, therapists rated all disclosures as less helpful than did clients.

Schwartz and Bernard (1981) conducted a study which sought to discover the degree of congruence of therapists' and patients' evaluations of therapy on a session-by-session basis and in retrospect. Clients were found to evaluate therapy more positively than therapists at every phase of treatment-- beginning, middle and end as well as post-treatment. Although therapists demonstrated an awareness of this discrepancy, they significantly underestimated its magnitude. Results also suggested that patients and therapists hold consensual views when evaluating the initial phase of therapy, less similar views during the middle phase, movement toward similar views near the ending stage, and, once again, similar views post-treatment.

Implications of the Research Literature

Research literature regarding what contributes to an effective therapeutic experience when healing from childhood sexual abuse is limited. One study suggested that helpful aspects included validation, advocacy, empathic understanding, and absence of contempt or punishment (Armsworth, 1989). Some insight into what survivors find helpful in treatment can be gained by reviewing research on group treatment of survivors. Literature on group therapy for survivors of childhood sexual abuse suggests that helpful aspects identified by clients included being able to share with others, feeling understood, learning they were not alone, realizing they were not as different as they thought, and being able to talk openly about the abuse (Carver et al., 1989). In addition, other factors identified as therapeutic in group therapy included catharsis, self-understanding, learning to take responsibility, and cohesiveness (Wheeler et al., 1992). However, the relevance of this research to individual therapy is restricted since some of the helpful aspects identified include qualities that are not necessarily present in individual therapy such as being part of a cohesive group, learning vicariously, and learning they were not alone or different (Bonney et al., 1986; Carver et al., 1989; Wheeler et al., 1992). There is a definite need for more research which focuses specifically on the treatment of survivors of childhood sexual abuse.

Another limitation of existing literature is that the vast majority of the literature regarding therapy for survivors of sexual abuse is based mainly on subjective judgments by therapists about what works in treatment (Hill & Alexander, 1993). This over-reliance on therapist perceptions is present even though there has been some indication that clients' and therapists' perceptions and opinions differ regarding the treatment of sexual abuse (Bonney et al., 1986; Hill & Alexander, 1993). In fact, research regarding client and therapist perceptions suggested that discrepancies between clients' and therapists' views occur frequently and that therapists are often unaware of these differences (Caskey et al., 1984; Dill-Standiford et al., 1988; Fuller & Hill, 1985; Thompson & Hill, 1991). Clients have been found to evaluate therapy more positively than do therapists (Hill et al., 1989; Schwartz & Bernard, 1981). Given that research has clearly indicated that therapists and clients often have differing points of view, researchers should assess both perspectives in order to gain a more complete understanding of the therapeutic process (Dill-Standiford et al., 1988).

Since information about what is effective in therapy specifically related to counselling adult survivors of sexual abuse is limited, such information has to be extrapolated from research regarding effective therapy with clients presenting other issues. Research on the effectiveness of therapy suggests that overall psychotherapy appears to be useful (Elkin et al., 1989; Elkin, 1994) and that the quality of the working alliance or therapeutic relationship is related to therapy outcome (Horvath & Symonds, 1991). Helpful aspects of therapy have been identified as including facilitative therapist characteristics (Elliott & James, 1989; Hill et al., 1988; Lietaer, 1992; Llewelyn et al., 1988), client unburdening (Elliott & James, 1989), self-understanding (Elliott & James, 1989; Lietaer, 1992; Llewelyn et al., 1988), perceived therapist encouragement for gradual practice (Elliott & James, 1989), gaining a new perspective (Elliott, 1985), feeling understood (Elliott, 1985; Murphy et al., 1984), receiving advice (Murphy et al., 1984), and problem-solving (Martin & Stelmaczonek, 1988).

However, when extrapolating findings from research regarding effective therapy with clients presenting issues other than those related to sexual abuse, the limitations of such research must be considered. The vast majority of these studies are based on short-term counselling experiences (Dill-Standiford et al., 1988; Elliott, 1985; Fuller & Hill, 1985; Hill et al., 1988; Hill et al., 1989; Llewelyn et al., 1988; Martin & Stelmaczonek, 1988; Schwartz & Bernard, 1981; Thompson & Hill, 1991). Also, the clients involved have often been dealing with issues less complicated or traumatic than sexual abuse (Caskey et al., 1984; Dill-Standiford et al., 1988; Elliott, 1985; Fuller & Hill, 1985; Hill et al., 1988; Hill et al., 1989; Horvath & Symonds, 1991; Llewelyn et al., 1988; Martin & Stelmaczonek, 1988; Murphy et al., 1984; Schwartz & Bernard, 1981; Thompson & Hill, 1991). In addition, many studies have involved clients who may not be representative of a true clinical population since the clients were university students (Dill-Standiford et al., 1988; Fuller & Hill, 1985), and, sometimes, these students were specifically recruited to be clients for the studies (Elliott, 1985; Martin & Stelmaczonek, 1988; Schwartz & Bernard, 1981; Thompson & Hill, 1991). Furthermore, for several of the studies, the therapists involved were inexperienced (Caskey et al., 1984; Dill-Standiford et al., 1988; Elliott, 1985).

Given that the much of the research has been based on short-term counselling focused on issues other than sexual abuse and it has sometimes involved volunteer clients and inexperienced therapists, the generalizability of the research to the treatment of survivors of sexual abuse is limited. Additional studies focussing on the treatment process in long-term therapy with experienced therapists and actual clients are required to develop a greater understanding of the what contributes to an effective therapeutic experience when healing from childhood sexual abuse.

This present study attempts to increase our understanding of therapy with survivors by including the perspectives of actual clients and experienced therapists who have been involved in long-term counselling relationships focused specifically on the treatment of childhood sexual abuse.

Chapter 3: Methodology

Research Approach

The intent of this research was to explore clients' and therapists' perspectives of the therapeutic relationship when healing from childhood sexual abuse. With this goal in mind, methods were considered to determine an effective approach for studying the experience of therapy when healing from childhood sexual abuse.

A review of the literature indicated that most of the research regarding the therapy process has been done from a quantitative perspective. Some of the assumptions underlying this method are that the phenomenon to be studied must be observable and measurable. In addition, more than one observer must be able to agree on the phenomenon's existence and characteristics (Valle, King & Halling, 1978). This positivistic approach emphasizes objectivity, quantification, precision, exactitude, operational definitions, repeatability, control, explanation, and prediction (Colaizzi, 1978; Seamon, 1982). Based on a dualistic view of science, the natural science perspective creates a strict boundary between the researcher and that which is researched. The phenomenon to be investigated is objectified and research measures are quantified to obtain objectivity. In this view, something is objective because "it is not burdened by the complications of the various ways people might experience [it]: objectivity resides wherever experience is not" (Colaizzi, 1978, p. 51).

In the traditional natural scientific approach, objectivity has come to mean the elimination of human experience. Thus, for human science research, which seeks to study people and to determine their experiences on a variety of dimensions, the natural science approach poses many difficulties. Colaizzi (1978) pointed out that "just as we implicity expect and accept a great distance between theory and experience in natural science, we implicitly recognize and demand a closer tie-in between theory and experience in psychological inquiry" (p. 49). How then can clients' and therapists' experiences of the therapeutic relationship when treating survivors of sexual abuse be investigated? Clearly a different approach, with more compatible underlying beliefs, is required.

Qualitative research in general offers an alternative paradigm for studying the experience of therapy. According to the phenomenological perspective, being objective does not mean denying one's experience (Colaizzi, 1978). Rather, when someone is said to be objective it means that, "his statements faithfully express what stands before him, whatever may be the phenomenon that he is present to; objectivity is fidelity to phenomena.... Objectivity, then, requires me to recognize and affirm both my own experience and the experience of others"(Colaizzi, 1978, p. 52). Phenomenological research is descriptive since its goal is to give a neutral, close and thorough account of the topic being investigated. However, phenomenology differs from other descriptive and qualitative methods because of its focus on the realm of experience (Polkinghorne, 1989). It provides a way to investigate the human inner world as legitimate subject matter for research. Phenomenology always begins from the perspective of consciousness and "allows that whatever presents itself to consciousness, precisely as it presents itself, is a legitimate point of departure for research" (Giorgi, 1994, p. 192).

There is no such thing as "the" phenomenological method (Colaizzi, 1978; Osborne, 1994). Rather, phenomenology is more of an orientation than a specific method. The particular procedures followed in any study depend upon the question being posed. Phenomenological methodology is not a set of uniform procedures which can be learned and applied. Rather, it consists of guidelines for engaging with and understanding the phenomenon as it is experienced. In addition, various branches of phenomenology exist such as pure or transcendental phenomenology and hermeneutic or existential phenomenology (Osborne, 1994). In contemporary phenomenological research, elements of the various approaches are often combined. Despite metatheoretical differences between the various types of phenomenology, what is important is that phenomenology as a whole offers an alternative world view to the traditional view of natural science that has dominated research in the past.

From a phenomenological perspective, experience is "not inside us but instead our experience is always of how we behave towards the world and act toward others" (Colaizzi, 1978, p. 52). The phenomenological world-view is contextual, for phenomena are deeply embedded in the world. Persons are considered "of" and not "in" the world since human existence and the world are so inextricably involved in one another (Colaizzi, 1978). This is very different than the natural science view which maintains that human existence and nature are independent of each other. That is, in natural science, dualism is assumed. Phenomenology, on the other hand, is holistic. Human beings and nature co-exist by defining and influencing each other. The phenomonological notion of intentionality describes human existence and the world constituting a unity so vital and basic that either one is inconceivable without the other. Thus, the two co-exist by reciprocal implication, neither creating or causing the other (Colaizzi, 1978; Seamon, 1982; Valle et al., 1978). Intentionality addresses the ongoing dimension of consciousness, that individuals are always in relation to that which is beyond them. All human impulses and actions do not exist unto themselves but are directed towards something and have an object. Thus, the phenomenological world view maintains that the person and his or her world co-constitute one another, and, in doing so, rejects the notion of causality in its linear or additive form that underlies natural science (Colaizzi, 1978; Seamon, 1982; Valle et al., 1978).

The foundation of phenomenology is experience. Phenomenology provides a way of exploring lived experience from inside the person rather than from the natural science perspective of observation and measurement. Personal descriptions of experience are seen as attempts to interpret and communicate awareness in a form that is meaningful. Naive descriptions of experiences are sought from participants and the researcher interprets those expressions in terms of meaning structures which capture the essence of the phenomenon. The researcher aims to reach the pre-reflective level of experience which precedes verbal articulation. "Going beyond the surface characteristics of the expressive behaviours to the meaning structures is what distinguishes phenomenology from natural science's observation and measurement of expressive behaviours" (Osborne, 1994, p. 172). Since individual experience is of prime importance, persons are considered experts in the sense that it is "their" experience. The task is to describe the nature of reality as taken up and posited by the participants. The researcher must clearly capture the way in which the phenomenon appears in everyday life by allowing the essential dimensions of the phenomenon to emerge (Giorgi, 1994).

Phenomenological research aims "to produce clear, precise, and systematic descriptions of the meaning that constitutes the activity of consciousness" (Polkinghorne, 1989, p. 45). The goal of phenomenology is to describe and understand phenomena in the participants' perceived immediacy, not to explain, predict, or control them as is the focus of natural science. The aim of data analysis in phenomenology is the explication of the essential structure of the phenomenon. While the phenomenon may reveal particular variations at any given time, the phenomenon is seen as having the same essential meaning when it is perceived over time in many different situations. Researchers aim to describe the structure of the particular phenomenon, that is, the commonality running through the many diverse appearances of the phenomenon (Valle et al., 1978).

Phenomenological research methodology has a close affinity with counselling practice (Osborne, 1990). It explores phenomenon from the inside perspective and it remains close to the meaning of human experience. Despite the similarities between phenomenology and psychotherapy, research in counselling has been dominated by studies based on natural science methodology. "Aspects of lived-experience, commonly observed during practice, were either inaccessible to prevailing quantitative methods or distorted by the need to operationalize the quality to be measured" (Osborne, 1990, p. 89).

Much of the research on the therapeutic process has focused on limited aspects of treatment or on pre- and post-therapy assessment measures to determine the impact of counselling on the client. However, studies which examine such specific aspects of the therapy process or which attempt to measure effectiveness of treatment offer little information about the experience of therapy. One of my presuppositions about the counselling process is that therapy involves much more than can be revealed by examining limited units such as response modes or nonverbal behaviours. I believe the therapeutic experience cannot be understood by examining or adding up the individual components of which it is comprised. That is, the psychotherapy process cannot be separated from the clients and therapists involved in the process. For these reasons, hermeneutical phenomenology--with its emphasis on human experience, co-constitutionality, and the insider's perspective--was chosen as an appropriate approach for exploring, discovering, and understanding the phenomenon of clients' and therapists' experiences in therapy for the treatment of childhood sexual abuse.

Presuppositions

Natural science attempts to eradicate or avoid researcher subjectivity and bias through experimental design. In phenomenology, however, researcher bias and subjectivity at every stage of the research design is seen as inevitable and not automatically negative. In phenomenology, nothing can be accomplished without subjectivity. Thus, eliminating it is not the solution. Rather, the issue becomes one of *how* the subjectivity is present (Giorgi, 1994).

When doing phenomenological research, part of the process is to examine biasing preconceptions and pull them into consciousness. In decisions such as which aspect of the content is investigated and what methods and procedures are chosen, the presence of the researcher is recognized as unavoidable. Rather than attempting to eliminate such influences through experimental design, the phenomenological researcher attempts to articulate predispositions and biases through a process of rigorous self-reflection called reduction or bracketing (Giorgi, 1994).

In reduction, the researcher aims to bracket all past knowledge or theories about the phenomenon being investigated in order that the phenomenon may be accepted precisely as it presents itself (Giorgi, 1994). It is the process by which expectations, prejudgments, beliefs, hypotheses and hunches are scrutinized, spelled out and consciously suspended so that the researcher can allow the phenomenon to be seen as it presents itself (Colaizzi, 1978; Osborne, 1990; Osborne, 1994). Bracketing is a means of "rendering oneself as noninfluential as possible during the process of research (neutral) in order to come up with valuable (value) findings" (Giorgi, 1994, p. 203). Through bracketing, presuppositions are set aside so that one may see the phenomenon as it presents itself and so that biasing preconceptions are not imposed upon research participants.

Whereas natural science research attempts to achieve objectivity, in phenomenological research bracketing explicitly acknowledges the preconceptual aspects of all research methods (Colaizzi, 1978; Osborne, 1990; Osborne, 1994). From a phenomenological perspective, "the articulation of one's approach facilitates the struggle to hold in abeyance those interests and presuppositions that may detract from the aim of description" (Peterson, 1994). In addition, through bracketing, the researcher's orientation is made clear so that results can be judged in accordance with the particular perspective from which it has been illuminated (Peterson, 1994). The knowledge gained through phenomenological research is not considered objective, but rather it is perspectival (Osborne, 1990). The aim of phenomenology is presuppositionless description. Since this is not possible in an absolute sense, the goal is "to admit as explicitly as possible the presuppositions that do exist" (Giorgi, 1986, p. 101).

I was not disinterested in the topic of clients' and therapists' perspectives of the experience of treatment when healing from childhood sexual abuse. Rather, both professionally and personally, I was deeply interested in discovering what could be learned by listening to the experiences of both those who had been sexually abused in childhood and of those who have helped them to heal. Having experienced differences in perceptions as both a therapist and a client has peaked my curiosity about the experience of therapy from the perspectives of both clients and therapists. As both a client and a therapist, I have found that some interventions have had little effect when greater results were anticipated; meanwhile, other seemingly insignificant comments have led to tremendous shifts. My initial interest in the topic of childhood sexual abuse came from my having been sexually abused as a child. My own healing process has involved years of therapy, considerable reading, extensive writing, and continual self-reflection. In addition, as I have pursued my professional goals, I have received substantial training regarding therapy with survivors of sexual abuse. However, I believe that it has been my work with survivors themselves that has continued to foster my interest in this area. I am constantly amazed by the courage and tenacity shown by individuals as they heal from the effects of childhood sexual abuse.

Some of the presuppositions which I bring to this research include my beliefs about people in general and about therapists and clients in particular. I view each person as unique with experiences which are uniquely his/her own. I value each individual's perceptions and believe that people can hold differing opinions or views that are equally valid. I maintain that people are basically good and that, given the circumstances, they are doing the best they can at any given time. I believe that people want to overcome adversity and that they strive toward personal growth and self-fulfilment. I consider change and growth to be lifelong processes in which all human beings engage, in some form or another.

For me, psychotherapy is one vehicle people may choose in their search for fulfilment and personal growth. Thus, in my opinion, clients are people who have chosen to attend therapy as a vehicle for overcoming adversity, facilitating self-reflection, and stimulating growth. I believe that people are incredibly strong and resourceful and that they have the ability to overcome incredible pain and suffering; however, I also think that sometimes individuals lose sight of their abilities and personal resources. One of my biases is that being a competent therapist involves considerably more than theoretical training and book knowledge. I place less emphasis on a therapist's model or techniques and more value on the therapist-client relationship. I am convinced that therapists have an obligation to be "self-aware"--to be aware of and reflect on their own issues, struggles, and strengths and to continue to strive for personal growth. If therapists are not self-aware, they will have blind spots that will interfere with their ability to effectively counsel their clients.

I also bring to this research presuppositions regarding sexual abuse and the process of healing. From the studies I have reviewed and the survivors I have met both in a professional capacity and in my personal life, I am convinced that childhood sexual abuse occurs at alarming rates and that it has potentially serious and lasting effects. While I do not believe that every survivor of sexual abuse suffers major effects or requires therapy to heal, I do feel that most survivors, particularly those who have experienced repeated or extreme forms of sexual abuse, would benefit from counselling. In addition I acknowledge that, in many instances, long-term therapy is needed due to the resulting issues such as lack of trust and safety, deadened affect, low self-esteem, and feelings of guilt and shame. I am convinced that the effects of sexual abuse can be horrendous and far-reaching. However, I am equally convinced that healing is possible and the negative effects can be overcome.

Finally, in examining the presuppositions which I bring to this research, my beliefs regarding "effective" therapy must be considered. Before commencing this research project, I examined my past experiences as a client in order to explore my perceptions of what contributed to therapy being effective for me. Perhaps my beliefs are best illustrated by a few of my summary thoughts in my pre-interview bracketing notes regarding my work with one therapist: "The therapist needs to be skilled, knowledgable and self-aware and the client needs to be dedicated and open....It isn't just her and it isn't just me. It's how we are able to work together....What makes therapy effective with [my therapist] and me is our relationship". I have seen therapists of varying theoretical orientations using widely discrepant techniques experience success with clients. It seems to me that successful therapy goes beyond a theoretical approach or a series of techniques. Rather, my hunch is that the relationship between the client and therapist is of primary importance to the process and outcome of therapy.

In my view, therapists and clients both have valuable insights into the therapy process and can provide accurate descriptions of what was helpful or effective. Since it is the client who is living each day of his or her life, I place more emphasis on a client's report of helpfulness than I do on whether there was a change on some "objective" measurement of symptoms such as anxiety or depression.

By bracketing my presuppositions about people, clients, therapists, sexual abuse, healing, and effective treatment, my aim is to allow the data to speak for itself so that I am able to better understand the experience of healing from childhood sexual abuse. It is hoped that this study will yield some enlightening and useful information regarding the experience of being in therapy for the treatment of childhood sexual abuse so that therapists, myself included, are better able to support survivors on their healing journey.

The Participants

Of the three therapists who participated, the researcher had briefly met one of them once and had never met or spoken to the other two prior to commencing the research. The three therapists were women with graduate training, ranging in age from 43 to 50. Two of the therapists worked in private practice while the other was employed by a nonprofit agency. All three were experienced chartered psychologists who had been practicing from 9 to 14 years. One therapist described her approach as feminist, another as eclectic with a feminist slant, and the third as structural integrative.

Although therapists were encouraged to select male clients as well, all of the clients chosen were female. The clients ranged in age from 47 to 54. One client was married, another divorced, and the third was single. One client was a lesbian. Two of the clients had children and grandchildren. All of the women in this study had experienced repeated sexual abuse from multiple offenders related to the women. The offenders included mothers, fathers, brothers, and uncles. In addition, family acquaintances, babysitters, and neighbours were also offenders. For these women, the sexual abuse occurred throughout their entire childhoods--starting from their earliest memories and ending when they left home. Of the three clients in this study, two had some form of counselling prior to their work with these particular therapists. The length of time that the participants had worked together ranged from three to seven years. All of the clients had completed therapy a minimum of one year prior to becoming involved in this study with the exception of a few occasional follow-up sessions.

Procedure

Once the literature review was completed, the next task involved the researcher engaging in several sessions of free-writing which explored beliefs, biases, hunches, experiences, and questions regarding the therapy process with survivors of sexual abuse. This writing process enabled the researcher to gain clarity around the phenomenon to be investigated and assisted the researcher in exploring and examining underlying presuppositions. This journaling continued throughout the project.

Subsequent tasks included preparing materials to solicit and screen participants, obtain permission from participants, collect background information, and guide interviews. These materials are included in the appendices. Having outlined the research to be engaged in and having developed the necessary forms, ethics approval for the study was sought and received.

In order to obtain participants, therapists were contacted by telephone and provided with a brief description of the project. Therapists were solicited through the researcher's personal contacts and through recommendations by other therapists. In order to eliminate the inclusion of relatively inexperienced participants, screening criteria for therapists included that they possess a graduate degree, have at least five years of counselling experience, and belong to a professional regulatory body. Those therapists who expressed interest were mailed an information package which included a letter to the therapist with more detailed information about the study (See Appendix A), a letter introducing the project to clients who may be interested (See Appendix B), and a consent form for clients to sign which enabled therapists to release clients' names and telephone numbers to the researcher (See Appendix C).

After therapists received the information package and expressed continued interest in the research project, the next step in participant selection was to solicit clients from these therapists' caseloads. Since the aim of this study was to explore therapists' and clients' experiences of treatment when healing from childhood sexual abuse, therapist-client pairs who had worked together were selected. By choosing dyads who had worked together, the counselling process was able to be placed in the context of a therapeutic relationship. Client selection was left to the therapists' discretion with the provision that clients chosen meet certain selection criteria. Therapists were to select clients with whom they had worked with for at least six months. In addition, the clients were to have completed therapy with some success as defined subjectively by the therapist and client. Clients selected must have been sexually abused on more than one occasion by someone known to them, and the clients were required to have at least one clear memory of sexual abuse involving physical contact of a sexual nature (e.g., thereby excluding sexual abuse which was limited to exhibitionism or being shown pornography). The therapists contacted the clients and provided them with information about the study (See Appendix B). It is important to note that this method of client selection is inherently biased since the therapists made the decision about who to select from their caseloads.

Those clients who were interested were given the choice of contacting the researcher directly or having the researcher contact them. Two of the clients contacted the researcher directly while the other one gave the therapist permission to provide the researcher with her name and phone number. All of the participants were offered an initial meeting to discuss the study and to have questions or concerns addressed prior to consenting to participate. One participant accepted this offer while the others expressed feeling that their questions were answered fully through telephone conversations. Individual meetings were arranged with each participant with an emphasis on choosing a time and location best suited to the participant.

The researcher began each interview by establishing rapport and attempting to join with the participant. The purpose of the study and the format of the interviews were explained and questions were answered. Confidentiality and the option to discontinue the study at anytime were emphasized and written consent was obtained from all participants (See Appendix D). The interview format was open-ended with minimal structure in order to allow the participants' experiences to emerge as spontaneously as possible. Interviews with clients began with an open inquiry about the experience of being in counselling. Interviews with therapists began with a similar inquiry into the counselling process, taking care to focus the therapist on the particular client involved in this study rather than on therapy with survivors in general. For example, the usual opening prompt was, "Tell me about your experience in counselling with *client's or therapist's name*". Probes such as "tell me more about that" were used to gain clarification and elaboration. Prompts from the interview guides (See Appendix E and F) were initiated when participants came to closure on specific points or experiences they were describing. However, the majority of the time the interview guide was only used just prior to ending each interview, with the aim of ensuring that all of the issues had been addressed so there would be some continuity in the topics covered in each interview. Prior to concluding the interviews, participants were given several opportunities to provide additional comments by responding to questions such as "Is there anything else that might help me to understand your experience more fully?". Interviews ranged from one and one-half hours to two hours and were audiotaped and then transcribed by assistants who took oaths of confidentiality.

Data Analysis

The aim of phenomenological research is to understand the structures, logic and interrelationships of the phenomenon under investigation. The purpose of data analysis is "to derive from the collection of protocols, with their naive descriptions to specific examples of the experience under consideration, a description of the essential features of that experience" (Polkinghorne, 1989, p. 50). From the participants' descriptions, the researcher must glean an accurate essential description of their contents and the particular structural relationship that coheres the elements into a unified experience.

Since the majority of the tapes were transcribed by an assistant, the researcher first listened to each tape while reading the transcript in order to ensure accuracy and to gain a sense of nonverbal cues such as tone and pacing. The transcripts or protocols of the six interviews were read and re-read by the researcher to allow the researcher to acquire a feeling for the data and to become immersed in the descriptions of the participants' experiences. Each protocol was considered statement by statement with respect to its relevance to the research question, namely the participant's experience of the treatment process. Relevant phrases, sentences or paragraphs (i.e., meaning units) were extracted and these significant statements were subsequently paraphrased. When paraphrasing, careful attention was paid to remaining as close to the participants' actual language and intended meaning as possible. Having paraphrased the significant statements, the researcher then allowed for the emergence of themes.

Having completed this process of choosing significant statements, paraphrasing meaning units, and allowing themes to emerge for each of the six protocols, the analysis was reviewed. Irrelevant descriptions which had been included were eliminated, as were repetitions. Unique items were noted and included. At this point, the researcher had completed a within persons analysis of the six protocols which began with the verbatim transcripts of each protocol and ended with relevant theme units (i.e., significant statement, paraphrase and theme). These analyzed protocols were then reviewed by two colleagues for feedback regarding how close the paraphrases and themes related to the participants' original statements.

After having analyzed each transcript individually, each participant was contacted and interviews involving each client-therapist dyad were arranged. These joint interviews involved the client and therapist discussing their perspectives regarding what was helpful or effective in therapy. These interviews were unstructured and the researcher mainly observed the interactions and listened to the dialogue, offering only occasional prompts. Like the previous interviews, these interviews were audiotaped, transcribed, and analyzed with an aim toward allowing the emergence of themes. Through the analysis of the protocol for each joint interview, new themes emerged as did support for existing themes. This information was incorporated into the previous analysis of each participant's protocols.

The next step involved comparing the experiences of the clients with the experiences of the therapists. This involved pooling the theme units into two groups--one made up of clients and one of therapists. First, all of the client themes were clustered into groups of themes or "thematic clusters". These thematic clusters were named, completing the first order analysis. The first order thematic clusters emerge when related themes from the transcripts were combined so as to present a detailed description of an aspect of the experience of the treatment process when healing from childhood sexual abuse.

Then, these clusters of themes were grouped and named, which completed the second order analysis. The second order thematic clusters represent a further abstraction of the first order themes and result in a concise, encompassing representation of the experience of the therapy process with survivors as expressed explicitly or implicitly in the clients' descriptions. That is, this higher-order cluster of themes aims to define the structure of the phenomenon. This process of clustering themes was then repeated for the theme units from all of the therapists' descriptions. This process of sorting pooled themes first for the clients and then for the therapists represents a group analysis of the experiences for clients and therapists.

The second order themes were referred back to the original interview transcripts in order to check their validity. Reflection to determine if each protocol exemplified the thematic structure was done by asking questions of the data such as, "Is there anything contained in the original protocols that isn't accounted for in the clusters of themes?" and "Do the clusters of themes contain anything which isn't implied or stated in the original protocols?". Exceptions and unique experiences were re-examined against the clusters of themes to see how they did or did not fit. The thematic structure was refined in order to account for all the salient descriptive data.

Another level of analysis involved comparing the experience of each client with the experience of her particular therapist to examine any differences in perceptions within each dyad. Thus, the theme units for each dyad were pooled together. This process resulted in three pairs of transcripts, each pair involving a therapist and client dyad who had worked together. Then, the process of allowing first order themes to emerge and subsequently clustering and naming them (i.e., second order analysis) was repeated. This process of sorting pooled themes represents a between persons analysis for the members of each counselling dyad. That is, it is a within dyad analysis. As had been done for the between group analysis, the final structure of second order themes of the within dyad was compared to the original protocols and reflected upon to determine whether information had been erroneously included or excluded.

After having completed the between group and within dyad thematic analyses, it was discovered that the within dyad analysis (i.e., comparing themes from each client with those of her therapist) supported the information gained through the between group analysis (i.e., comparing the pooled themes from all clients to all therapists), but this further level of analysis offered little additional understanding or insight. For this reason, the between group analysis was chosen as the level on which to focus the presentation and discussion of results.

The final step of the data analysis involved integrating the results into an exhaustive written synthesis describing the experience of the therapy process when healing from childhood sexual abuse. Since the between group analysis suggested several differences between clients' and therapists' experiences, a different summary description was needed for each group. The summary of the clients' themes was presented to all of the clients for their review (See Appendix G) while the therapists reviewed a summation of therapists' themes (See Appendix H). Each participant was asked to comment on whether the description adequately reflected her experience. Relevant new data that emerged from the participants' comments was integrated into a revised, final description which accurately reflected the lived experience of the participants.

Reliability and Validity

In natural science research, reliability generally refers to consistency, replicability and stability of measurement. However, in phenomenological research, reliability is viewed as indivisible from validity because reliability is concerned with the mode of instrumentation. That is, the instrument used for measurement varies according to what you are measuring. For example, a measuring cup is used to measure volume whereas a ruler is used to measure distance. Since something is always being measured, "the nature of the construct being measured will have an effect upon how it is to be measured (reliability)" (Osborne, 1990, p. 87). In this way, validity subsumes reliability (Maxwell, 1992; Osborne, 1990). According to phenomenology, questions related to concepts such as "inter-reliability" are rejected since phenomenology explores meaning and meaning is tied to each person's perspective or frame of reference. In phenomenology, rather than speak of reliability in the traditional sense, concepts such as intersubjective agreement and reflected subjectivity are considered.

Intersubjective agreement refers to the idea that human perception occurs within certain perspectives and contexts (Osborne, 1990). Thus, although there may be many interpretations of the same phenomenon, reliability can arise out of the inconsistency, variability and relativity of human perception. For example, different participants can be interviewed by different researchers, producing situations which are not repeatable. However, these multiple perspectives can lead to a unified description of a shared phenomenon--to a description of the essence of the phenomenon (Kvale, 1994; Osborne, 1990). While these different perspectives may reduce reliability as viewed by the traditional, natural science paradigm, these multiple perspectives are seen as an advantage in phenomenology since they may "obtain a broader and more richly nuanced picture of the themes focused upon" (Kvale, 1983, p. 89). Thus, due to the perspectival and contextual nature of human perception, intersubjective agreement refers not to the replicability of findings, but rather to gaining a greater understanding of the phenomenon being investigated through multiple perspectives (Kvale, 1983; Kvale, 1994; Osborne, 1990).

Reflected subjectivity suggests that sometimes a thoughtful, subjective opinion is more useful than an objective statement or fact. The focus with phenomenological research is on meaning rather than facts and stable meaning can transcend variable facts (Osborne, 1990; Kvale, 1983). A stable meaning of the phenomenon should result from the participants' various experiences because the researcher's accurate interpretation of the participants' individual descriptions leads to a more global understanding of the phenomenon. In other words, sometimes a therapist's or client's perspective may be more useful or offer more information than an "objective" measure.

One of the major threats to reliability and validity is the interpretive process involved in phenomenology. There is a risk that during the analysis of the interview transcripts, selecting and interpreting interview statements may be done in accordance with one's own preconceptions or prejudices. As Kvale (1983) stated, "extensive, complex and little structured interview material lends itself to be read like the devil reads the Bible" (p. 190). It is important to remember that there is "no absolute interpretation of the data and that interpretations can produce contradictory as well as coherent meanings" (Osborne, 1990, p. 87). Thus, the task of the researcher becomes one of presenting a particular interpretation as persuasively as possible by supporting it with references to the data. The final judgement is then left to the reader (Osborne, 1990; Polkinghorne, 1989).

Validity, in the traditional sense, refers to whether one has in fact investigated what one wished to investigate. In phenomenological research, validity is approached from a more general perspective--"as a conclusion that inspires confidence because the argument in support of it has been persuasive" (Polkinghorne, 1989). When validity is considered to mean defensible knowledge claims rather than a correspondence with an objective reality, validity is ascertained by examining potential sources of invalidity. "Validation becomes investigation, continually checking, questioning, and theoretically interpreting the findings" (Kvale, 1994, p. 167). The stronger the attempts at falsification that a proposition has survived, the more valid and trustworthy the knowledge (Kvale, 1994). There are four major ways to assess the validity of a phenomenological researcher's interpretations: bracketing, goodness of fit, convincing arguments, and external validation (Osborne, 1990).

Bracketing refers to the practice of the researcher explicitly stating biases and presuppositions regarding the phenomenon. In addition, clear descriptions of the procedure and data analysis are provided so that the reader is able to understand the researcher's interpretations of the data (Osborne, 1990). Thus, even though the reader may disagree with the interpretation provided by the researcher, there is clarity around how the researcher arrived at that interpretation. For this study on the experience of therapy with survivors of childhood sexual abuse, this aspect of validity was fulfilled in the methods chapter which described the researcher's presuppositions, delineated the procedures used, and explained the process of data analysis.

The second method of assessing validity involves checking the researcher's interpretations of the data for goodness of fit or congruence with the participants' experiences of the phenomenon (Osborne, 1990). In this study, the researcher presented each client with a written summary of the clients' themes (See Appendix G) and each therapist with a written summary of the therapists' themes (See Appendix H). Participants were asked whether the information presented reflected their experience, whether anything was included that did not reflect their experience, and whether anything was missing that was an important aspect. The comments from the participants are summarized in chapter four after the results have been presented.

The most crucial means of validating the interpretations of phenomenological research involves presenting convincing arguments (Osborne, 1990). The researcher aims to convince the reader as well as the research community of the accuracy and validity of the findings. "The degree of validity of the findings of a phenomenological research project...depends on the power of its presentation to convince the reader that its findings are accurate" (Polkinghorne, 1989, p.57). To achieve validity through convincing arguments, the reader must be able to follow the thought processes that have led to the conclusions presented and accept them as valid (Kvale, 1983; Osborne, 1990; Polkinghorne, 1989). In this study, in order to fulfil this aspect of validity, the researcher thoroughly described existing presuppositions, delineated and explained the procedures and data analysis, presented convincing arguments supported by data or quotes from the interviews, and sought feedback from fellow students and professors regarding the data analysis and final descriptions.

External validation provides a final check on the validity of the interpreted structure of the phenomena. This aspect of validity, often called empathic generalizability, refers to the extent to which the description of the phenomenon is congruent with people outside of the study who have experienced the phenomenon (Osborne, 1990; Polkinghorne, 1989). For example, in the case of this study, the question would be, "Does the description of the experience of therapy regarding the treatment of childhood sexual abuse resonate with other clients' and therapists' experiences of this phenomenon?". In order to assess this aspect of validity, the final description was shared with six other therapists and six other clients who had been involved in therapy focused on the treatment of childhood sexual abuse. The information gathered from this process is summarized at the end of chapter four after the results have been presented.

Chapter 4: Results

The interview data provide insight regarding what contributes to an effective therapeutic experience when healing from childhood sexual abuse. In individual and joint interviews, clients and therapists illuminated their experiences through descriptions. These descriptions were transcribed, creating protocols, which were then analyzed. The essential features that emerged through the phases of analysis resulted in a final thematic structure which describes the essential structures of effective therapy with survivors of childhood sexual abuse from the participants' perspectives.

Through the data analysis it became overwhelmingly apparent that it was not a certain therapy approach or any specific techniques that led to effective psychotherapy. Rather, it was the quality of the client-therapist relationship that resulted in effective therapy. For each of the two groups of participants, clients and therapists, nineteen first-order themes emerged which presented a detailed description of the experience of the therapy process. When these first-order themes were grouped or clustered, five second-order themes evolved which resulted in a concise representation of the experience of the therapy process with survivors as expressed explicitly or implicitly in the participants' descriptions. The first and second order themes for clients and therapists are outlined (Table 1, p. 42). By combining all of the therapist and client themes, a framework for conceptualizing the experience of being in therapy is created (Table 2, p. 43). In addition, brief descriptions of the client themes and therapist themes are provided (See Appendix I and J).

In this chapter, each theme is briefly described and supported by illustrative quotations from the interviews with participants. As the data is presented, similarities and differences in clients' and therapists' perceptions will be highlighted. Once the results have been presented, similarities and differences between clients' and therapists' perceptions will be examined in more detail. Also, a brief summary will be provided. And lastly, the validity of the results will be discussed.

Table 1

The Experience of Being in Therapy: First and Second Order Themes

	Client Themes		Therapist Themes
I.	Healing Foundation	I.	Healing Foundation
	1. Therapist Being Genuine		1. Client Being Motivated
	2. Client Being Motivated		2. Therapist Being Genuine
	3. Therapy--A Joint Venture		3. Therapy--A Joint Venture
II.	Building Blocks	II.	Building Blocks
	1. Unconditional Acceptance		1. Unconditional Acceptance
	2. Continual Validation		2. Continual Validation
	3. Sincere Compassion		3. Sincere Compassion
	4. Mutual Respect		4. Respect
III.	Threads That Bind	III.	Threads That Bind
	1. Safety/Trust		1. Safety/Trust
	2. Client's Needs as Focus		2. Client's Needs as Focus
	3. Therapist Availability		3. Rediscovering Client's Voice
	4. Containment and Closure		4. Therapist Integrity
IV.	Healing Through Relationship	IV.	Healing Through Relationship
	1. First Opportunity To...		1. Therapist as a Bridge
	2. Therapist as a Bridge		2. First Opportunity To...
	3. Healing Through Interaction		3. Healing Through Interaction
	4. Therapist Being a Role-model		4. Therapist Being a Role-model
	5. Therapist Being a Guide		5. Therapist Being a Guide
V.	Rewards of the Experience	V.	Rewards of the Experience
	1. Cherished Relationship		1. Cherished Relationship
	2. Client Healing		2. Client Healing
	3. Therapist Growth		3. Therapist Growth

Table 2

A Framework of the Experience of Being in Therapy

	Categories (Second Order Themes)	Clients' and Therapists' Themes (First Order Themes)
I.	Healing Foundation	1. Therapist Being Genuine 2. Client Being Motivated 3. Therapy--A Joint Venture
II.	Building Blocks	1. Unconditional Acceptance 2. Continual Validation 3. Sincere Compassion 4. Respect
III.	Threads That Bind	1. Safety/Trust 2. Client's Needs as Focus 3. Therapist Availability 4. Containment and Closure 5. Rediscovering Client's Voice 6. Therapist Integrity
IV.	Healing Through Relationship	1. First Opportunity To... 2. Therapist as a Bridge 3. Healing Through Interaction 4. Therapist Being a Role-model 5. Therapist Being a Guide
V.	Rewards of the Experience	1. Cherished Relationship 2. Client Healing 3. Therapist Growth

Healing Foundation

Three aspects contribute to the foundation necessary for healing: the therapist being genuine, the client being motivated, and the therapy process being entered as a joint venture. Clients seemed to place the most emphasis on the need for therapists to be genuine, whereas therapists emphasized the need for the clients to be motivated. Nevertheless, all participants identified these three aspects as essential components for effective therapy when healing from childhood sexual abuse.

Therapist Being Genuine.

Both clients and therapists identified the importance of the therapist being genuine. Clients described therapists as "real" people who were invested and fully present during counselling sessions. For example, one therapist was described as doing counselling with her "whole self". Clients gained a sense of therapists' being real through the therapists' sharing of personal information through self-disclosure. They described how the therapists' genuineness was conveyed by the therapists' direct and clear manner of speaking as well as by their openness in accepting responsibility for their mistakes. In addition, clients described feeling as though they were treated as people rather than as appointments.

> If you [i.e., the therapist] had acted like a...professional I wouldn't have been with you for six years...one of the things that was easy because you were just easy to be around and you weren't all hung up on yourself as being a psychologist...you related to me as a human being as opposed to somebody to study....That speaks to...the ease of being with you as a therapist. Because you're genuinely yourself and if you were to...have too many constraints it would feel like you were playing the therapist instead of being the therapist. So, I would much rather have you being you than you trying to...play the role.

Therapists also recognized the necessity for the therapist to be genuine. Therapists described themselves as honest, open, and sincere. One of the ways in which their genuineness was evident was by the sharing of their own experiences and feelings.

> So that's the beginning part, showing my own feelings...my face is very mobile. It shows everything or almost everything....So, that means some risk on my part showing tears, showing feelings when I know from years of experience,

> that's what creates the most safety zone sitting in that chair in a client when they see that it's genuine. That I can't sort of manufacture those looks on my face.

Client Being Motivated.

Another key ingredient for the foundation of the healing process involved the client being motivated. Clients characterized themselves as not having to be pushed because they were so motivated and, in fact, they expressed that sometimes it was the therapists who had to keep up with them. Clients indicated that they were "driven to heal" and they described themselves as persistent, determined, motivated and committed.

> I walked away from the experience realizing that Sharon was quite right...she said one day that...I was one of the most persistent people that she had ever met. Cause I just kept coming back for more, and coming back and coming back no matter how painful or how off balance I was. It was just once I got started on it, I had to see it through. I did an awful lot of work.

Therapists also saw clients as determined, highly motivated, and committed. They described the clients as courageous, strong, and very active in the healing process.

> Tammy was always from the very start, determined to get well, and she was willing to do whatever might help her get there. She was taking courses...she was going to groups...if I said have you thought about such and such she was signed up the next day. So that's how keen she was, and that continued all the way through. And it's my experience that the more that people are willing to do outside of their therapy sessions to keep the healing going, the better they do and she is a prime example of that.

Therapy--A Joint Venture.

In addition to the therapist being genuine and the client being motivated, the interviews indicated that the foundation of effective therapy is also rooted in the belief that therapy is a collaborative process in which both clients and therapists have contributions, responsibilities, and influence. Also, in this joint venture, both clients and therapists commented on how the client and therapist complemented each other.

For clients, therapy was seen as a joint venture where the therapist contributed knowledge and the client brought determination. Clients and therapists were both seen as having influence on aspects of therapy such as pacing and topic determination. Each client believed that she matched or complemented her therapist. In addition, clients experienced a sense that the joint venture of therapy has a dynamic or process of its own. For example, there was a sense that once the healing started and memories surfaced, it had to continue. Clients also believed that if something was missed or skipped over it would resurface so it could be resolved. For example, one client stated, "That was one thing we kept sort of talking about too...even if you don't get hold of a memory out loud, if it needs to come back it will and that very much happened".

Although clients believed therapy was a joint venture, they tended to attribute any difficulties that arose during therapy to themselves. Clients talked about how therapy was less effective when they disassociated or blacked out, when they misinterpreted what the therapist was saying, when they responded "immaturely", or when they would not talk about relevant issues.

> I didn't know, and so, of course, then it impeded my own progress because if there was something I was holding back, yet consciously I knew I should talk about, and I wouldn't, that would have an effect on the session....it was like turning off my ears and I didn't hear.

Therapists also recognized therapy as a joint venture, a collaborative process involving both the client and the therapist. They talked about "experiencing along with" their clients and doing things "together" and "with" their clients. They displayed trust in the therapy process, believing that therapy included easy times and difficult times, that if issues were missed they would resurface, and that even things that were not helpful in the short run were often able to be used for greater healing in the long run. Therapists' also described themselves as matching or complementing their clients.

> With Lisa I think the universe is a wonderful thing and so it's very interesting that she came earlier in my journey as a therapist and because we are quite similar in being introverts and introspective and intuitive and feeling judging types there was a match...so probably the fact that we were somewhat similar was probably helpful at that time.

Sometimes therapists attributed difficulties that arose during therapy to the dynamics of the therapy process such as transference, fear states induced by dealing with traumatic issues, or cycles of making progress and sliding back. Most times, however, therapists attributed difficulties to themselves. They identified personal areas that they questioned such as having limited knowledge and experience, having a tendency to be controlling and directive, being unprepared to deal with certain issues, and having personal issues that they have not yet resolved.

Building Blocks

Clients and therapists identified four building blocks that are required for a positive therapeutic experience: unconditional acceptance, continual validation, sincere compassion, and respect. These qualities were seen by both clients and therapists as essential to having a positive or effective therapeutic experience. They build the supportive atmosphere and relationship necessary for healing to occur.

Unconditional Acceptance.

Unconditional acceptance was identified by clients and therapists as a necessary building block. Clients identified the need for therapists to maintain an accepting, nonjudgemental, and open attitude at all times. Clients felt that who they were, what they disclosed, how they felt, and how they behaved were all met with unconditional acceptance on the part of the therapists.

> She was nonjudgmental and accepted me for the space I was in and each appointment that I had, the spaces were very different at times, but Karen's whole manner, physical manner and the nonjudgement were really important in me letting myself go back to think about the things that had happened...

In addition, clients expressed appreciation for the times when therapists conveyed acceptance through self-disclosing or story-telling which offered reassurance and normalized behaviours. Through the stories that therapists told, clients learned that they were not "weird", that other people experienced similar feelings, and that they were "normal".

> I would tell her some horrendous story, and she would come up with some [story or personal experience] and normalize it. "I remember Tammy feeling like

> that when I did this". So, all feelings are the same regardless of what they come from. [As a result, I'd think...] well, thank goodness, I'm normal. Now, I realize that the memories I had were abnormal, in so much as, particularly the scope of them, but they could be put into the context of going to the store or buying a new hat. You very much normalized it. And you did that all of the time. That was probably the better thing you could have done for me.

Therapists also emphasized the necessity of feeling unconditional acceptance for the client. This acceptance was conveyed through maintaining a nonjudgemental attitude, believing the client, and being spontaneous and genuine. One therapist expressed the need for "unconditional regard" for the client. The following quote illustrates one instance of a therapist conveying unconditional acceptance:

> She had slashed or cut one of her wrists and I guess she shared that with me...I put my fingers on the scar, I just put my fingers on the scar and then I didn't say anything....somehow there was a connection and it felt like she allowed a little bit of caring and that she felt cared for by me...

Continual Validation.

A second building block that participants identified as a requirement to creating a supportive atmosphere was continual validation. Clients' descriptions reflected their strong need to be validated and believed. They felt heard by the therapists and appreciated that the therapists validated their feelings, actions, and efforts. In fact, therapists validated everything about who the clients were. In addition, the therapists believing that abuse occurred was of prime importance.

> She never, never once said or did anything that led me to believe that she didn't believe what I said...and it's not the fact that she said, "I believe you". I don't know if she even said that, but I just knew that she did. Like, she never asked a question so that it sounded as if she was trying to quiz me like a cop.

Likewise, therapists recognized the necessity of this continual validation. Believing, acknowledging, affirming, and encouraging the client was seen as critical.

> How do I make it safe? When she started to tell me about it, validating it, like I believe in these things. I don't think they're crazy...that kind of statement, rather than the distance from it and not wanting to hear about it...

Sincere Compassion.

Also, sincere compassion was considered to be an essential building block for creating a supportive atmosphere. It allowed clients to talk openly about their experiences. Clients recounted how compassion was evident by therapists' willingness to work for little or no pay when clients' funds were limited. Also, it was evident by therapists' open sharing of their feelings, including tears, when they were touched by the clients' pain. For clients, sincere compassion by therapists included empathy, understanding, support, patience, caring, warmth, and love.

> I think she had tears in her eyes by the time I had finished and there wasn't anything coming out of her except love....she is just a very loving person to begin with, a very caring person...

Therapists also recognized the significance of sincere compassion. They described how their compassion was reflected by their commitment, their believing the client, their listening, their understanding, and their caring.

> If that meant that I had to cancel other appointments, if that meant I had to stay with her til midnight, whatever it took that day, she was not going home. It's easy to care for 50 minutes, but to have the commitment to disrupt other things, and...not everybody in the world is willing to go out on a limb and say I believe in your premonition and I'm going to help you.

Respect.

Participants described another key ingredient or building block for an effective therapeutic experience: maintaining an atmosphere of respect.

When clients mentioned respect, they described mutual respect. That is, in addition to feeling respected, clients also expressed the respect they had for the therapists. Clients described how respect was fostered by clients being recognized as unique individuals. In addition, clients emphasized that they felt as though they were treated as equals. All of the clients talked extensively about feeling respected by the therapists.

> I had a big fear about losing what up until that time I felt was her, and to say high opinion of me is kind of, is not the right way I want to phrase it. She treats her clients with a great degree of respect and I was afraid I suppose even

> after that incident had happened that things had changed that she wouldn't love me as much as before...

Despite the inherent imbalance of power in the client-therapist relationship, clients felt they were able to have power and control in the relationship. Clients expressed feeling that their choices within sessions were respected.

> I was very withdrawn...spoke basically, answered questions that she asked, but didn't volunteer much information at all because I didn't know what she would say, or what she would do. And, she respected that....She never pushed past what I felt I could handle in any one session. I never felt forced.

For therapists, the emphasis was on their respect for the clients rather than on the clients' respect for them. Each therapist expressed respect for the individuality, uniqueness, and specialness of her client. They emphasized that they viewed the clients as equals. Therapists related numerous qualities that they admired and respected about the clients. The respect that therapists had for clients was evident in how the therapists supported clients' choices, how they viewed clients to be the experts on their own experiences, and how they believed clients had all the resources necessary to heal.

> ...what I believe has to be there always...is a...respect for the client, a belief that she has the resources to deal with her problems and the realization that I cannot possibly know who she is or what her issues are and I have to be the follower most of the time...

Threads That Bind

With the healing foundation and building blocks in place, the beginnings of a positive therapeutic relationship, and thus an effective therapy experience, are established. The threads that bind all of these together are needed--threads which contain aspects of the relationship that are constantly present. These aspects weave in and out, building upon the foundation and tying the building blocks together.

The participants' interviews indicated that clients and therapists had differing perceptions as to which aspects of therapy constituted the threads running throughout effective therapeutic relationships. Both clients and therapists agreed that two of the crucial threads included safety/trust and the necessity of the client's needs remaining as the focus. However, clients' descriptions suggested that two other significant threads included therapist availability and containment and closure. Descriptions by therapists, on the other hand, identified rediscovering the client's voice and maintaining therapist integrity as significant threads. The similarities and differences in client and therapist perceptions will be discussed in more detail later. For now, each theme is described.

Safety/Trust.

Safety and trust were seen by both clients and therapists as crucial for healing to occur. Clients recalled how safety and trust were facilitated when therapists displayed strength, ensured self-care, had clear boundaries, were totally focused on the clients, and disclosed that they were also survivors. Clients described the necessity of safety and trust being present:

> I wasn't sure until I became very comfortable, and I developed a strong trust with Karen, and felt that, you know, it was the right thing to do. Because I felt that if I was talking about the abuse, what else horrible was going to happen?....I just had a great deal of difficult convincing myself that I was doing the right thing at that time....in some ways, [it was] probably about three or four months before I started to feel I could trust her. Before I felt safe.

Therapists also described safety and trust as essential. They described how they established trust and safety by offering reassuring messages, by respecting the client, by being clear with their boundaries, and by demonstrating strength. Although therapists acknowledged the importance of trust, they emphasized their obligation to be trustworthy.

> ...one of the things that I always say to...survivors...right from the first session I say to them I never, never expect you to trust me. People you should have been able to trust as a little kid often betrayed your confidence and I'm not going to do that. What I am going to ask you to do is to learn to trust yourself and I am going to be as trustworthy as I know how to be....so that feels really important, trustworthiness is what I aimed for, and by the end of therapy typically clients trusted my good will quite a lot but I don't expect them to and I never use those words trust me, never, never...

Client's Needs as Focus.

In effective therapy experiences, both clients and therapists recognized the importance of the client's needs being paramount. Clients described therapists as flexible--open to doing whatever or using which ever resources would help the client. Clients expressed appreciating that therapists encouraged them to enrol in various courses, attend support groups, read about sexual abuse, and connect with other professionals in order to meet their needs. In addition, clients recognized that the pacing of therapy was aimed at meeting their needs.

Therapists also emphasized the importance of client needs being the focus throughout therapy. In order to meet the client's needs, each therapist was flexible, available, open to other resources, and willing to let the client set the pace. Therapists were willing to go beyond the limits of a traditional therapy relationship when it was deemed as something that would be beneficial to the clients.

> ...because of the nature of the abuse that we were dealing with, I needed to be more flexible in how I proceeded. Like the three hour sessions...they were mandatory. So again the rule of the client is the expert and it's her needs that determine how this will work....going to the movie together, I have not done that with any other client in 25 years. But it was important to do with her. The speaking together [at conferences]--I haven't done that with anybody else. Just to be more open to what would be therapeutic and beneficial and to go out of the prescribed hours, setting.

Therapist Availability.

For clients, one of the threads that binds the therapy relationship together is therapist availability. While therapists acknowledged availability as one way to meet client needs, clients placed considerably more emphasis on it. Clients described relying on and being dependent on the therapist. The therapist was often seen as a lifeline, as someone who stood by the client and who never abandoned her. In fact, each client knew that her therapist was still available in a professional capacity if she wanted to return to therapy. Clients expressed comfort in knowing that the therapist was available.

> ...if she was just away a week kind of locally or somewhere she would actually give me a phone number of where she was and I think probably, when she was away I probably only ever used it once but certainly I did phone her between sessions as the years went on. Yes I did, yes I did and I am glad that I had that opportunity. In fact I don't think I could have managed without her. It was crucial for her to be right there when I wanted her...

> ...that was one of the things she told me initially. She said, "If you were to lose your job tomorrow, you could still continue therapy". She said it would not stop. That's not going to deny you.

Containment and Closure.

The final thread that clients described as important in therapy included achieving containment and closure both throughout the relationship and at the end of the therapy. While therapists acknowledged the need for containment and closure, they placed much less emphasis on its significance than did clients. For clients, the need for containment or closure on issues that surfaced, on each session, and, on the therapeutic relationship, was seen as critical. Throughout therapy, containment and closure minimized client vulnerability, provided clients with a sense of control, and supported efforts to celebrate healing or progress.

> Closure each session was really important. If you get to a place where you're scared, and particularly with me with the amount of fear that I'm living, and you've got to go a whole week with it, you're barely going to make it. But, I think you kept it contained enough so that I only go this much of scaredness in me and we could look after this much of scaredness. That's not to say that we did that all the time. I mean, I lived some terrible weeks when I left here. But, do you hear what I'm saying? There was some closure, if we could.

Rediscovering Client's Voice.

As mentioned previously, therapists identified safety/trust and maintaining the clients' needs as the focus as two of the threads that bind the therapy relationship together. Other crucial threads described by therapists included rediscovering the client's voice and ensuring therapist integrity.

Therapists made conscious efforts to help clients find their own voice. That is, therapists encouraged empowerment and facilitated opportunities for clients to have choice, control, and power in the relationship. Emphasis was placed on supporting clients to connect with their own thoughts, feelings, and beliefs. Efforts were made to not rescue or unduly influence clients.

> ...one of their coping strategies may have been to be very accommodating, they need to find their own voice and that will not happen if the therapist takes

> charge and becomes the expert. With Tammy I remember in her first session she constantly talked about what her husband thought of her--she had no voice of her own. And I was intent therefore on helping her to find her own voice. So after she had over half a dozen times told me what her husband thought of her, I said well, what about you? And we learned that...she accommodated him to the extent that she only saw herself through him.

Therapist Integrity.

For therapists, one of the threads that ran throughout the counselling relationship was the imperativeness of therapist integrity. Therapists emphasized the need to be aware of their own issues, personality traits, and limits. Therapist integrity was evident by their willingness in accepting responsibility, their openness to making referrals, their commitment to seeking consultation, and their devotion to being self-aware. This commitment to self-awareness is evident in one therapist's statement, "I am really self-reflective and I really honour this work and I really believe very strongly the clearer I am as a person the more helpful I can be to others". In addition, therapist integrity was apparent by the importance placed on having responsible, ethical, and clear boundaries:

> ...a great regard for boundaries; that means not touching inappropriately or without permission. That means, very responsible about, being on time, that means also the therapist taking care of herself or himself so that this group does not have to deal at all with the therapist's needs.

Healing Through Relationship

If therapy is entered with a strong healing foundation (i.e., therapist being genuine, client being motivated, and therapy viewed as a joint venture), and the building blocks are present (i.e., unconditional acceptance, continual validation, sincere compassion, and respect), and these are woven together throughout therapy with the threads that bind (i.e., safety/trust, client's needs as focus, therapist availability, containment and closure, rediscovering the client's voice, and therapist integrity), then, healing can occur through the therapeutic relationship. Healing through the therapeutic relationship occurs in many ways: the relationship acts as a first opportunity for clients to experience many things, the therapist acts as a bridge, healing occurs through interaction, the therapist acts as a role-model, and the therapist acts as a guide.

First Opportunity To....

Both clients and therapists recognized that the therapy relationship acted as a first opportunity for clients to experience many things. Clients placed more emphasis than therapists did on the therapy relationship providing first opportunities. In their interviews, clients described feeling that it was in their relationships with the therapists that they had their first occasion ever to experience unconditional acceptance, continual validation, sincere compassion, respect, safety, and trust.

> ...if I were to describe the seven years with Sharon the only word that comes to mind is the fact that she loved me and unconditionally in a way that I had never been loved before as a child, or as an adult, or as an adolescent, the way everybody is entitled to be loved and usually aren't.

The therapy relationship was the first opportunity clients had to focus on their own feelings and needs, to feel as though they had an ally, and to develop a sense of hope. For the first time, clients experienced having power, choice, and control in a relationship. In addition, clients described how it was within the therapy relationship that they first disclosed, were able to talk about the abuse, and were believed:

> And, that was the first time anybody had ever said that to me. That, it was okay to talk about these things that were inside....she was never judgemental, ever. She never said, she never denied any of the...that it couldn't have happened, or it didn't happen, or it's your imagination...And, my mother never believed any of it.

Although therapists placed less emphasis on it than did clients, therapists also identified the importance of the therapy relationship providing many first opportunities. For example, therapists described how their relationship with clients was the first opportunity for clients to view themselves as people who were more than their pain or their abuse--they were worthwhile, loveable, valuable individuals. In addition, therapists described that how it was within the therapeutic relationship that clients first recognized and examined many issues.

> ...another thing that came out...was that she didn't have any idea that the problems she was having were related to the abuse that she had experienced....she didn't get the connection. She didn't realize there would be any connection.

Therapist as a Bridge.

Another manner in which healing occurs through the therapeutic relationship is by the therapist acting as a bridge. Clients described one way in which this bridging occurs--when the therapist does things for the client until the client is able to do things for herself. For example, the therapist loves, nurtures, supports, cares for, respects, accepts, trusts, believes in, and values client even when she is unable to do those things for herself.

> I'm a firm believer that it's real difficult to love yourself unless somebody loves you first...Sharon taught me that by loving me, I then learned how to love myself, how to take care of myself, because I used her as a role-model. It was also true of the trust.

Clients explained that the therapist also acts as a bridge by "reparenting" the client--by displacing early negative messages with more positive ones. In addition, clients described bridging that occurred when clients would think about the therapists and the things they had said during sessions in order to cope during difficult times. For example, remembering reassuring things the therapist had said or imagining what the therapist might say helped clients to cope during difficult times between sessions. And, finally, clients described how the therapist acted as a bridge by helping clients to connect with themselves--with their own thoughts, feelings, and body sensations.

> And, because I had been taught not to feel anything, I couldn't tell her how I was feeling. So, she would describe some of the feelings..."Do you have a stomach ache? Do you have a headache? Do you feel pain anywhere? ...what's going on in your mind right now?

Therapists also emphasized their role as a bridge as one of the ways in which healing occurs through the therapeutic relationship. For example, by maintaining faith in the clients' ability to heal, therapists provided hope for the clients when clients felt they had little hope. In addition, therapists recalled times when they acted as a bridge by caring for and loving the client until the client was able to do those things for herself.

> ...I had bought some little brass bells and...I gave her one, I just, you know, when that rings it's just a reminder that you're not alone and so those were the kind of grounding things that I used....having an object that was grounding and that was connected with somebody in the world who cared about her was

> important cause she certainly didn't care very much about herself, there was an extreme self-loathing there that was very powerful....And so there was a gradual movement from my being the one who cared about her, to teaching her to care about her, to caring for herself.

Also, therapists became a bridge between old, unhealthy messages or beliefs and the development of new, more positive ones by offering reassurance, encouragement, and validation. Therapists acted as a bridge between the clients and the community by advocating for the clients and connecting them with other resources. And finally, therapists described how they acted as a bridge by being an intermediary person or step as clients developed healthier coping mechanisms and healed past pain.

> So when I first started working with her she would sometimes slash and then she could tell me about it and we could talk about it and what was progress with her was then that the slashing would become more infrequent, and then what happened over time was that she would talk about wanting to slash and she would connect with me in those moments she would become aware that something was going on when she wanted to slash.

Healing Through Interaction.

Another way in which healing occurred through the relationship involved clients resolving issues through the interactions between the client and therapist. This dynamic of past issues surfacing within the relationship is often referred to as transference. However, the idea of healing through interaction goes beyond the common understanding of transference since healing through interaction involves, as the name implies, not only having the issues surface, but also resolving them. Furthermore, clients and therapists described healing as having occurred through a variety of interactions within the therapeutic relationship, not just interactions triggered by the client's projection of unresolved issues. For example, role-playing was one way in which healing occurred through interaction in the therapy relationship. In addition, both clients and therapists described an additional dimension of healing that occurs through interaction: learning which occurs within the therapy relationship is generalized to other relationships and interactions.

Clients described how healing occurred through interaction when they were able to work through their own issues by learning new ways to interact in the therapy relationship:

> I learned how to be angry with her, which was really interesting because in my family you weren't allowed to be angry....You stuff your anger....so, anytime I would get angry at Sharon, and she always knew when I was pissed at her...if she knew I was angry with her she would give me a certain amount of time to bring it up on my own. And then if I didn't bring it up, and I was still angry, then she would kind of very gently broach...you think you might be angry with or you think you might have something to say about this incident...when I first started to talk to her about my anger, it used to scare me to death because I thought if I'm angry with her she's not going to love me anymore. She is not going to like me. I just can't get angry with her. So it was real, real difficult over the course of those six years to go through that fear and start to tentatively talk to her about, you know, when this happened I really got ticked off...and she was like totally open to the whole thing...

Therapists also identified this process of clients' own issues surfacing and being resolved through interactions in the therapeutic relationship.

> The other thing that wasn't always helpful was that I didn't always keep my word perfectly. I once had said to her that I would phone....and I can't remember if I didn't phone at all...or whether I phoned later than I indicated that I would and so that was really hard for her and quite appropriate, that wasn't fair on my part to not contact her as I said I would and sometimes I would not contact her as quickly as she wanted me to which, when it was not a promise on my part, but that would trigger original experiences by my not being there perfectly. So we worked out a lot of mom stuff I think... physically, I don't know if I remind her of her mother because her mother is taller, but just the way that I dress and then in not to be there for her perfectly that would trigger her mom not being there. Not helpful in the short run I think it was really terrifying for her, but in the long run it's been really important, that is we have used even the non-helpful things to heal...

Therapist Being a Role-model.

Clients and therapists described another way in which healing occurred through the relationship--the therapist acted as a role-model for the client. Clients expressed appreciating it when therapists modelled safety, comfort and openness by participating in exercises, such as pounding pillows, along with the clients. Clients also emphasized the importance of therapists modelling clear boundaries. In addition, clients described having consciously chosen the therapist as a role-model very early in therapy. And, in some instances, therapists had considerable impact and provided hope by self-disclosing a history of childhood sexual abuse and subsequently modelling that being a survivor and being emotionally healthy is possible. One client, who knew that her therapist was also a survivor of childhood sexual abuse, commented:

> I had really out of balance concepts of what love was and what trust was and what safety and security and all the major issues that you do with sexual abuse or abuse of any kind for that matter, but, so I was looking at this person who was contradicting all the reality that I had ever grown up with and it was really mind blowing and I thought gee, maybe I could be like that too someday. You know because that presented the picture of health.

Therapists also recognized the importance of acting as a role-model for clients. They described the importance of modelling appropriate boundaries, safe expression of feelings, and healthy self-care. Therapists used modelling to teach things like how to parent the inner child and how to appropriately express anger. In addition, therapists modelled self-acceptance:

> Typically I have used my mistakes, it's like do it again and that's incredibly healing as a modelling with clients you know, that if I'm not perfect then but I am still an okay human being and I am entitled to go for work that I want etcetera that they can do that too.

Therapist Being a Guide.

In all of the participants' interviews, therapists were characterized as guides. Therapists were described as facilitating the process, deepening the experience, fostering empowerment, and generating insight.

Clients indicated that some of the things that therapists did to guide the healing which occurred in the therapeutic relationship included challenging clients' perspectives (e.g., through questioning, probing, exploring, and inviting), tracking clients' progress (e.g., through focussing the sessions and monitoring progress both within sessions and throughout therapy), clarifying clients' issues (e.g., through observing, listening, reflecting, summarizing), encouraging the clients' progress (e.g., by nurturing, reassuring, reinforcing, affirming, and valuing the client), and teaching the clients new skills (e.g., through sharing ideas and information). One client described how the therapist guided the process to a deeper level:

> So she said, "So that's all the pain you have, eh?". Somehow she has got me right down here now,...what do you mean that's all I got? "All I see Tammy is a few lines on a paper." So she is now asking me the amount of pain. Well my reaction to that was I felt like filling this whole book like that, that's how much pain I've got. But you see how she has got me to admit how much pain I'm in. Not just this little bit but I said...I could draw through this whole book and it would not get rid of the pain. So that is a good example of Sarah, how she just got underneath it and made me realize, wow, I am looking at a lot of pain here.

Therapists also identified that one of the ways that healing occurred through the therapeutic relationship was by their acting as guides. Therapists described how they guided the clients' process by providing direction, reframing issues, inviting clients to explore different perspectives, tracking clients' progress, and focussing the sessions.

> We both remember me saying to her at times, "We're chatting. You're paying too much money. Life's too important for us just to chat." And, that would get her back into doing some real work.

Rewards of the Experience

The experience of being in therapy led to both expected and unexpected rewards. Both clients and therapists identified these rewards as developing a cherished relationship, client healing, and therapist growth.

Cherished Relationship.

Both clients and therapists spoke extensively about the specialness of the relationship that developed through the therapy process. Participants were clear that the relationship was not a friendship, yet it was unique, special, and cherished.

Clients described an immediate attraction to the therapists, a sense of "clicking", and a feeling that fate brought them together. Each client was grateful that she had the opportunity to work with her therapist and each expressed a sense of indebtedness to her therapist. Each client appreciated knowing that she could return to her therapist for additional counselling if the need ever arose. Clients viewed the relationship real--there was a definite bond, a sense of human connectedness. They expressed feeling that the relationship was unique and special.

> I never really asked her well did you connect better with me than anybody else, although I think on some level I probably wanted to ask her that, you know the little kid in you wanting to feel special, but we talked about how well we connected and she used to call it a heart connection. We connected at the heart. And that made a difference. It made all the difference in the world cause all the times that I'd felt as if I just couldn't deal with one more little shitty thing I knew I was connected to one person and, if nobody else in the whole world loved me one person loved me...that was extremely important to me, to have that one connection. To be connected at the heart. So that was very important. That was really special.

The significance of the cherished relationship was also evident by clients' ongoing treasuring of the relationship even after closure:

> I just really feel that it doesn't matter how old I live to be, Karen will always be there [in my heart]. She will always have a very special place, I mean, she did things for me that nobody else...either ever tried to do or ever could do.

Therapists also described the relationship as cherished. Each therapist echoed the sense of realness and human connectedness described by each client. Therapists expressed feeling as though they matched or complemented their clients and they talked about how much they liked their clients.

> ...but, I think what enabled me...to work with her throughout those seven years of horrendous memories and issues was that I liked her....I liked her...because of what I could sense about her and I could just sense that good strong spirit and it was something I could respect without knowing her. So that made her delightful to work with.

Therapists recognition of the uniqueness of the relationships with their clients was clear as they often used phrases such as "that is not something I do routinely" and "I haven't done that for anyone else". Also, therapists acknowledged the importance of the relationship by their open door policy which allowed clients to return for further therapy if needed.

Client Healing.

Both clients and therapists recognized that client healing occurred in many ways. Through therapy, clients developed understanding, reconnected to themselves, regained control, and reconnected to the community.

Clients described how they developed understanding--they gained insight and faced past issues that were buried. They described how they reconnected to themselves by learning to trust and value themselves, to respect and nurture themselves, and to recognize their own strengths and resources.

> But, through all my therapy with Karen I have learned to have hope, to believe in myself and to realize that I have an obligation and a right to look out for my own needs, concerns, and goals.

Clients described regaining a sense of control that resulted in increased independence, the ability to manage their own lives, feeling strong, having choices, and developing healthier coping skills and clearer boundaries. And finally, clients described their reconnection to the community. They described how they began having more mature relationships with friends, they resolved issues in relationships with family members, they built support networks outside of therapy, and they returned to work or school.

Therapists mentioned numerous areas in which they observed client growth. They described clients as having developed understanding about their past and having reached a point of being able to "put it to rest and get on with [her] life". Therapists marvelled at how clients reconnected with themselves--with their own voice. Also, therapists portrayed client growth as involving clients being able to regain control over their lives. For example, clients learned how to manage their depression with diet and exercise rather than with medication. And finally, therapists observed client healing as clients reconnected with the community. Therapists saw that clients were having more intimate relationships with friends and family members. Clients were giving back to the community by speaking at workshops and professional meetings about abuse. They were encouraging other people to seek counselling to deal with abuse issues and they were pursuing self-growth through different avenues.

> At the end she was doing the kinds of things one needs to do if they are not going to be dependent on their therapist anymore for what they need, emotionally. She had formed a close relationship with two women who she had been in a survivors' group with and was meeting with them regularly, so she had people other than me to talk to about the really hard stuff about. And she was taking courses on religious matters and spirituality and was really exploring with other people...she had already put herself in a position where she could go further than what she could go with me.

Therapist Growth.

Clients and therapists both recognized that, throughout the therapeutic relationship, not only did clients grow, but so did the therapists. Therapists grew both personally and professionally by gaining insights, exploring their own issues, gaining knowledge, learning new skills, and broadening their experience.

Clients described their awareness of how the therapists had grown through the therapy experience. There was the sense that therapists gained confidence, insight, experience, and new skills.

> And she as a therapist evolved in the course of time....when I first started seeing her...she was a young therapist in terms of experience, and in the middle of my therapy, she became more confident in her abilities and much more sure of herself, she was more grounded.

Therapists described how they grew, both personally and professionally, throughout the experience of being in therapy with their clients. Through the therapeutic relationship, therapists were challenged to learn and to grow.

> ...she was the first cult survivor that I had worked with so I learned a great deal. I learned as much as she did if not more in this relationship....I think, how much I learned from working with Tammy, how much I had to stretch and grow. You know, I had to stretch as a therapist, I had to stretch and grow in knowledge, I had to read greatly, went to workshops. I grew professionally. I grew personally. Spiritually I grew.

Since the client and therapist dyads had been involved in long-term counselling relationships, some of the growth therapists experienced occurred as a result of gaining knowledge and skills over time. Therapist growth also occurred as therapists explored personal values and beliefs that arose from being in relationship with the clients.

> I would never have been forced to examine and develop my own spirituality had it not been for the demands you made of me. So, I grew in a way which I never would have anticipated because of our work together.

Similarities in Client and Therapist Perspectives

From the perspectives of both clients and therapists, effective therapy was seen as beginning with a strong healing foundation involving a client who is motivated, a therapist who is genuine, and a view of the counselling relationship as a joint venture or collaborative process. In addition to a strong healing foundation, clients and therapists in this study believed that building blocks such as unconditional acceptance, continual validation, sincere compassion, and respect were required in order to create a supportive atmosphere. Also, clients and therapists agreed that crucial threads running throughout therapy included safety and trust being maintained and the client's needs remaining as the focus. Furthermore, all of the participants in this study characterized several ways in which healing occurred through the therapeutic relationship: by the relationship presenting clients with new opportunities, by the therapist acting as a bridge, by the relationship creating a context in which healing could occur through interactions, by the therapist being a role-model, and by the therapist being a guide. And, finally, clients and therapists agreed that the rewards of the experience of being in an effective therapeutic relationship included client healing, therapist growth, and the development of a cherished relationship.

Differences in Client and Therapist Perspectives

Clearly clients' and therapists' experiences of being in therapy are similar. However, as might be expected, they are not identical. Since both clients and therapists offer valuable information about what is useful in therapy, examining the differences in their perceptions is worthwhile. Examining these differences in perceptions does not suggest that either perspective is right or wrong. Rather, it is important to explore these differences so that a greater understanding of what is helpful in treatment when healing from childhood sexual abuse can be gained.

Through analyzing the participants' descriptions, several differences in their perceptions emerged. Clients in this study placed more emphasis on the need for therapists to be genuine whereas therapists placed more emphasis on the necessity of clients being motivated. Another interesting difference involves the quality of respect as one of the building blocks of a positive therapeutic relationship. Each client described respect in terms of mutual respect. There was emphasis on their feeling respected by the therapists as well as on their respect for the therapists. However, therapists mainly discussed respect in terms of their respect for the clients. Although there seemed to be some acknowledgement that the clients respected them, their descriptions of respect were focussed on their respect for the clients.

Perhaps the most striking difference between clients' and therapists' descriptions of effective therapy experiences involves their characterizations of what constitutes the threads that bind the therapeutic relationship together. Both clients and therapists agree that safety/trust and maintaining the client's needs as focus are essential. However, other aspects seen as most crucial by clients included the therapist being available and having containment and closure on issues both throughout and at the end of therapy. There is no doubt that therapists recognized these aspects as crucial. However, in their descriptions of their experiences, these were not elements that were emphasized or, sometimes, even addressed.

Another difference in clients' and therapists' perceptions regarding the crucial threads which bind the relationship together was that, while clients emphasized therapist availability and containment and closure, therapists emphasized the importance of rediscovering the client's voice and of maintaining therapist integrity. Clients were aware of being reconnected to their own voices, but their descriptions of this process were placed in the context of it being one of many ways in which healing occurred. For therapists, this reconnecting of each client with her own voice was a constant, conscious effort that was made a priority throughout the relationship. Similarly, clients recognized the need for therapists to maintain integrity, and, perhaps, some of this is reflected in their respect for the therapists. Had the therapists not acted in respectful and ethical ways, this aspect of therapist integrity may have been given more attention by clients. However, in the present study, when clients described their experiences they placed much less emphasis on therapist integrity than did the therapists. For therapists, maintaining integrity was a crucial and essential theme throughout the therapy relationship.

A final interesting difference between clients' and therapists' descriptions of the experience of being in therapy involves their views on how healing occurs through the relationship. Clients overwhelmingly emphasized healing occurring because the therapy relationship acted as their first opportunity to experience many things such as safety, trust, respect, and validation. Therapists recognized the client healing that occurred by the relationship being a first opportunity for many new experiences; however, therapists placed substantially less emphasis on this than did clients.

As the previous examples illustrate, clients and therapists often have different perceptions of the therapy relationship. These differences highlight the importance of considering both perspectives when exploring what contributes to effective therapy with survivors of childhood sexual abuse. As one therapist explained,

> What was instructive for me...was in realizing that the things that I had carried and had been upset about in terms of not having been helpful in your process had not been of concern to you....Therapists are not always that spot on about what clients think or feel about a particular thing. So I may think I've done really well and the client goes home and thinks what a shitty session or the other way, you know, that was a screw up and it wasn't even important to the client.

Summary

Clients' and therapists' descriptions of their experiences in effective therapy for the treatment of childhood sexual abuse send a very clear message: the therapy relationship plays a pivotal role in the treatment of childhood sexual abuse. From the participants' descriptions, a new framework for conceptualizing the treatment process with survivors has emerged. This framework incorporates five categories: the healing foundation, the building blocks, the threads that bind, healing through relationship, and rewards of the experience. In order to discuss the various aspects of the therapeutic relationship, the framework proposed uses separate categories and distinct themes within those categories. However, it is critical to realize that, in practice, these categories and themes are overlapping, nonlinear, and interdependent.

The overlapping nature of the themes is evident by considering some examples. Clearly, sometimes a therapist's response may convey both acceptance and compassion. Similarly, at a given point in time, the therapist may be acting as a role-model and a guide. In addition, this overlapping may occur between categories. For example, a therapist may be focused on assisting a client to rediscover her voice (i.e., a thread that therapists identified) while at the same time acting as a guide (i.e., one of the ways in which healing occurs through the relationship).

As mentioned previously, this framework is nonlinear. That is, the relationship does not develop by moving through each category in a step-by-step manner. Rather, the various themes interact with each other in an ongoing, recursive fashion. For example, the therapist being available between sessions may be interpreted as compassion by the client, thereby enhancing the level of trust and safety in the relationship, which may in turn lead to client growth which could subsequently enhance the client's motivation thereby leading to further healing for which the therapist offers validation which further enhances trust.

And finally, many of the themes in this framework are interdependent. For example, without the client being motivated it is unlikely that healing will occur in the relationship. Similarly, unless the client feels accepted, trust and safety are not likely to develop. In addition, unless the client respects the therapist, it is unlikely that the therapist will become a role-model for the client.

From the participants' descriptions, a framework emerged to assist in understanding the treatment process with survivors of childhood sexual abuse. This framework emphasizes the critical role that the therapeutic relationship has in the treatment process. However, healing that occurs through the therapeutic relationship is a complex and dynamic process. The various categories and themes in the framework both influence and are influenced by one another. Despite this complexity, by sharing their experiences, the clients and therapists who participated in this study have provided a window into the experience of being in therapy for the treatment of childhood sexual abuse.

Validity

In qualitative research, there are four major ways of assessing the validity of a researcher's interpretations: bracketing, convincing arguments, goodness of fit, and external validation (Osborne, 1990). The processes of bracketing and presenting convincing arguments were described previously in chapter three. Now, goodness of fit and external validation are examined.

Goodness of Fit.

This method of assessing validity involves checking the researcher's interpretations of the data for goodness of fit or congruence with the participants' experiences of the phenomenon (Osborne, 1990). In this study, the researcher presented each of the three clients with a written summary of the clients' themes (See Appendix G) and each of the three therapists with a written summary of the therapists' themes (See Appendix H). Participants were asked whether the information presented reflected their experience, whether anything was included that did not reflect their experience, and whether anything was missed that was an important aspect of their experience.

After reviewing the summary of client themes (See Appendix G), the three clients expressed that the summary was an accurate reflection of their experience. For example, when asked if the information presented reflected their experiences, responses included "Yes it does, in all areas" and "Yes, very much so". Some of the comments by clients provided additional reinforcement for the aspects described. For example, with regard to the theme of containment and closure, one client commented, "at the time it was important, but in hindsight it was very important".

Two of the clients indicated that in the summary of client themes nothing was inaccurate or missed. One client suggested that healing also occurred through the relationship through role-playing, that an important quality the therapists modelled was clear boundaries, and that one of the ways in which therapists acted as a guide was by teaching concrete coping skills. All of these comments were considered by the researcher to be congruent with the descriptions provided by participants. These aspects had been included in the complete descriptions of each theme, but were not adequately emphasized when each theme was briefly summarized. Thus, the researcher ensured that these aspects were clearly explained in the final description of the phenomenon.

In order to assess goodness of fit with regard to the therapists' themes, the three therapists who had participated in this study were provided with a summary (See Appendix H) and asked to offer feedback. Overall, the therapists believed that the descriptions were accurate reflections of their experiences. Nevertheless, the therapists offered several points of clarification. For example, one therapist emphasized her belief that as a therapist she cannot "give" a client power or control, but rather, she can "facilitate" that process. While this could be construed as merely a difference in language, it was thought to reflect an important underlying belief and approach to counselling. Thus, the final descriptions of the therapists' themes incorporated this subtle but important difference.

Other points that therapists clarified or expanded upon involved ways in which the therapist acted as a bridge. For example, one therapist identified a need for the therapist to be recognized as a bridge to providing hope for the client by maintaining the belief that the client would heal. Similarly, another therapist commented that the therapist also acted as a bridge to the community by connecting the client with resources and by advocating for the client. These comments had been present in the complete descriptions of the themes, but the specific examples had been left out of the summary in order to condense the information.

Another comment made by a therapist included clarifying that the therapist remains available to the client in a professional capacity after closure, not in a way which may be misconstrued as a friendship. The ongoing professional availability was certainly what the researcher intended to convey and thus, the researcher ensured that the presentation of the results conveyed that ongoing availability was related to any future therapy needs that the clients may have.

Finally, one therapist indicated that she preferred the term "unconditional regard" over "unconditional acceptance" since it conveyed something more active. In addition, she indicated that she felt that the unconditional regard was better described as being present from the beginning as part of the foundation where as therapist genuineness was more of a building block since, in her view, it was something that built the other things. However, this therapist also acknowledged that these differences were "all a matter of emphasis". The researcher chose not to incorporate these suggestions into the final presentation of the data since the therapist making these comments did not disagree with the content of what was being proposed and she recognized the differences she highlighted were related to emphasis. In addition, the other therapists indicated that the proposed framework was congruent with their experiences.

In summary, the proposed framework seems to be an accurate reflection of the clients' and therapists' experiences. The comments offered by the participants provided additional examples of how things like bridging or modelling occurred, offered some clarification on aspects that may have been presented in a vague manner, highlighted some differences in language, and described some variations in emphasis. However, overall the framework was considered to accurately reflect their experiences. The majority of these comments were incorporated into the final description of the experience of therapy when healing from childhood sexual abuse. Since the participants had an opportunity to review the framework and offer feedback, more confidence can be placed in the accuracy of the results presented.

External Validation.

External validation, often called empathic generalizability, refers to the extent to which the description of the phenomenon is congruent with people outside of the study who have experienced the phenomenon (Osborne, 1990; Polkinghorne, 1989). Thus, six clients and six therapists who had been involved in therapy regarding childhood sexual abuse were provided with the summary of results. They were asked whether the information adequately reflected their experiences, whether anything was included that should not be included, and whether anything was missed. The clients and therapists who read the summaries were asked to answer the questions in regard to a therapeutic relationship in which they had been involved.

Despite efforts to include male therapists or male clients in this process of assessing empathic generalizability, all of the clients and therapists who provided responses were females. The clients who provided feedback were between the ages of 34 and 59 and the length of time working with their therapists ranged from one year to eight and one-half years. All of the therapists who commented on the summaries were between the ages of 35 and 59 and based their responses on clients they had seen for one and one-half years to two years.

Five of the six clients who were not original participants in this study but who read the summary indicated that the proposed framework was reflective of their experiences. One client stated, "I am surprised that you captured so much of the experience. It is almost as if you were there". The sixth client indicated that "for the most part" the ideas were reflective of her experience and added that "Perhaps I wasn't as 'needy' or needed more of a sense of facilitation of my own process". Other comments offered by these clients were related to areas that participants had identified but that perhaps needed more emphasis in the summary. For example, one client identified the need for the therapist to "hold the hope" for her until she was unable to maintain hope for herself and two of the clients mentioned the necessity of the therapist having clear boundaries.

All of the therapists who commented on the summary of the proposed framework indicated that it was reflective of their experiences. One therapist stated, "I am amazed at how well this information reflects my experience. It was like you have read my mind". Another therapist stated, "I found myself as I was reading this material being 'reminded' of the experience, of what it was like for me, and having a 'yes' within".

One therapist offered some clarification around unconditional acceptance, emphasizing that while she unconditionally accepts what happened to her client, how her client feels and what her client's process is, she does have conditions on how her client behaves. Another therapist indicated that "While I would not describe it as inaccurate or false, I did not experience 'First Opportunity To...' as being very significant in this experience". It is interesting that this therapist did not view the "First Opportunity To..." as an important aspect of therapy with her client since, among the original participants, therapists placed considerably less emphasis on this aspect than clients. Since the client to whom this therapist is referring is unavailable to offer feedback, it is impossible to know whether in this counselling relationship there truly was little significance to the role of the therapy relationship providing first opportunities or whether the client would perceive this aspect of the relationship as significant.

The feedback received from six clients and six therapists who have been involved in therapy focussed on childhood sexual abuse and who were not participants in the study suggests that the description of the experience of therapy regarding the treatment of childhood sexual abuse is congruent with their experiences. This demonstrates that there is external validity or empathic generalizability for the framework proposed. However, more generalizability could be achieved by receiving feedback from additional clients and therapists, particularly males.

Chapter 5: Discussion

This research project aimed to increase our understanding of therapy with childhood sexual abuse survivors by exploring, from the perspectives of both therapists and clients, what contributed to an effective therapeutic experience. Clients and therapists who had worked together described their experiences of the treatment process when resolving issues related to childhood sexual abuse. Through their descriptions, it became apparent that it was the quality of the client-therapist relationship that resulted in effective therapy. All of the participants' experiences of the therapeutic relationship had five dimensions: a healing foundation, building blocks, threads that bind, healing that occurred through the relationship, and rewards of the experience. Within these five areas, there were some differences between what clients and therapists emphasized, and, in one area--the threads that bind--there were some substantial differences as to what aspects were considered essential.

While the framework that emerged from the participants' descriptions is a new way of conceptualizing the therapeutic relationship, many of its components have been previously identified by researchers. In the discussion of the results, the data will be revisited and compared to existing literature on the effectiveness of therapy. Then, the implications of the present study for the treatment of childhood sexual abuse will be explored. Also, the limitations of the present study will be examined. In addition, the implications of this study for future research will be considered. And finally, some concluding remarks will be offered.

The Data Revisited

The Relationship.

The participants in this study unanimously expressed that it was the quality of the therapeutic relationship that resulted in effective therapy. The importance of the therapeutic relationship has been well documented in research and, in fact, the quality of the therapeutic relationship has been identified as the second largest contributor to psychotherapy outcome (Lambert & Cattani-Thompson, 1996; Miller et al., 1995).

For decades, research has focused on exploring what makes therapy effective and, more specifically, what influence the therapeutic relationship has in terms of the effectiveness of therapy. There is considerable research that indicates that therapy is effective; however, research also suggests that, overall, no one approach is more effective than another (Elkin et al., 1989; Garfield, 1990; Gelso & Carter, 1985, 1994; Greenberg, 1986; Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Lambert et al., 1986; Miller et al., 1995; Stiles et al., 1986; Strupp, 1982; Walborn, 1996).

Since different approaches result in roughly the same degree of effectiveness, researchers have examined the common factors between approaches that may be accounting for the effectiveness of psychotherapy. These common factors include aspects of the therapeutic relationship that are present regardless of the theoretical orientation used by the therapist. One of the most recognized common factors known to be present in successful counselling is a good working alliance or therapeutic relationship (Bordin, 1979; Gelso & Carter, 1985, 1994; Horvath & Symonds, 1991; Lambert & Bergin, 1994; Nelson & Neufeldt, 1996; Strupp, Wallach & Wogan, 1964). After doing a meta-analysis of 24 studies, Horvath and Symonds (1991) concluded that while researchers define the alliance or relationship in various ways, common aspects of the definition included the concepts of collaboration, mutuality, and engagement.

Other studies have suggested that some of the factors common to various therapy approaches include the core conditions of client-centered counselling--empathy, warmth, and positive regard (Lafferty, Beutler & Crago, 1989; Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Patterson, 1984). While some researchers contend that the common factors of warmth, empathy, and positive regard are both necessary and sufficient conditions for client change, others view the common factors as important but not sufficient for change to occur (Lambert & Cattani-Thompson, 1996).

Researchers and clinicians seem to be moving toward the view that techniques and attitudes cannot be easily distinguished, and, because they are so interwoven, research cannot separate their unique contributions to outcome (Butler & Strupp, 1986; Lambert & Bergin, 1994). Separating specific techniques from common factors is of little value since techniques can never be offered in a context free of interpersonal meaning (Lambert & Cattani-Thompson, 1996). That is, techniques are always provided within the context of a relationship. While the exact nature of common factors and the degree to which they influence the effectiveness of therapy has not been determined, research clearly indicates that factors common across treatments are accounting for a substantial amount of improvement found in psychotherapy clients (Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Miller et al., 1995).

Butler and Strupp (1986) contend that psychotherapy is the "systematic use of a human relationship for therapeutic purposes" (p. 36). Since existing research has identified that the quality of the client-therapist relationship is important to the effectiveness of therapy, it is not surprising that clients and therapists in the present study identified the therapeutic relationship as contributing to the success they experienced in therapy.

Healing Foundation.

One dimension of the framework that emerged in this study is the healing foundation. Three aspects were identified as creating the foundation necessary for healing: the client being motivated, the therapist being genuine, and the therapy process being entered as a joint venture.

In the present study, the effectiveness of therapy was described by both clients and therapists as being influenced by the high degree of motivation on the part of the clients. Clients were described as motivated, determined, committed, and persistent. Research on client variables which contribute to success in therapy has highlighted client motivation as having considerable influence (Lambert & Cattani-Thompson, 1996; Mahrer & Nadler, 1986; Miller et al., 1995; Strupp et al., 1964). In fact, Miller et al. argued that "the most influential contributor to change is the client....[and]...no change is likely to occur without the client's involvement" (p. 57).

Another part of the foundation that participants emphasized was the need for the therapist to be genuine--to be open, honest, and sincere. Therapists were seen as real people who disclosed information about themselves, and, they treated clients as real people rather than as appointments. The presence of therapist genuineness in effective therapy relationships has received extensive support in the research literature (Gelso & Carter, 1985, 1994; Lambert & Bergin, 1994; Miller et al., 1995; Orlinsky & Howard, 1967; Patterson, 1984; Strupp et al., 1964). Gelso and Carter (1994) define genuineness as "the ability and willingness to be what one truly is in the relationship--to be authentic, open, and honest" (p. 297). Miller et al. addressed the need for therapists to be genuine in order for a positive bond or alliance to be formed. In addition, many humanistic therapies seem to suggest that "a real relationship exists to the extent that the therapist is willing to be open and genuine about his or her feelings in the relationship" (Gelso & Carter, 1985, p. 184).

The final component of the healing foundation is that therapy was viewed as a joint venture. That is, it was seen as a collaborative process in which both clients and therapists have contributions, responsibilities, and influences. Furthermore, in this joint venture, therapists and clients were seen to match or complement one another. The recognition of therapy as a joint process involving collaboration between the client and therapist is well documented (Elliott, 1983; Gelso & Carter, 1985, 1994; Horvath & Symonds, 1991; Lambert & Cattani-Thompson, 1996; Miller et al., 1995; Orlinsky & Howard, 1967). Similarly, the benefits of appropriately matching clients and therapists are recognized (Beutler, 1989; Bordin, 1979; Nelson & Neufeldt, 1996). Horvath and Symonds (1991) support the idea that therapy is joint venture, since in their view, both the therapist and the client "make important contributions to the formation of an effective therapeutic partnership. An adequate representation of the relationship therefore would have to reach beyond the examination of the therapist's contributions and take account of the collaborative aspects of the relationship" (p. 139).

Building Blocks.

Building blocks constitute the second dimension of the framework for an effective therapeutic relationship. Clients and therapists identified four building blocks that they felt were required for a positive and effective therapeutic experience: unconditional acceptance, continual validation, sincere compassion, and respect. These qualities were seen as essential in building a supportive atmosphere and a strong therapeutic relationship.

For participants in this study, unconditional acceptance was seen as the therapist maintaining an accepting, open, and nonjudgemental attitude. Extensive support for the importance of acceptance in the therapeutic relationship exists (Cooley & Lajoy, 1980; Lambert & Bergin, 1994; Miller et al., 1995; Wheeler et al., 1992). Research indicates that therapy is more effective when the client perceives the therapist as nonjudgemental (Cooley & Lajoy, 1980; Miller et al., 1995) and that healing is facilitated when the therapeutic relationship is characterized by acceptance (Lambert & Bergin, 1994).

Clients in this study highlighted the importance of being validated by the therapists. This meant having their experiences believed and feeling affirmed, acknowledged, validated, and valued as a person. Long ago research recognized the importance of the therapist communicating the attitude that the client was worthwhile as a person (Strupp et al., 1964) and the importance of providing validation has been recognized in more recent studies as well (Armsworth, 1989; Hill et al., 1988; Hill et al., 1989). Miller et al. (1995) emphasized the need to listen for and validate client's strengths and resources.

Sincere compassion was the third building block clients and therapists described as necessary for facilitating an effective therapeutic experience. This compassion was seen to include empathy, understanding, support, patience, caring, warmth, and love. The word "compassion" was chosen rather than the more commonly used term "empathy" in order to remain as close to the participants' language as possible. In addition, it was believed that the phrase "sincere compassion" captured the qualities of love and caring more effectively than did the word "empathy" or "understanding". However, it is important to note that empathy and understanding are also important parts of what the clients and therapists described as compassion.

The importance of sincere compassion in the outcome of therapy, particularly the aspects of it that refer to empathy and understanding, are supported by extensive research (Armsworth, 1989; Carver et al., 1989; Cooley & Lajoy, 1980; Elliott, 1985; Lafferty et al., 1989; Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Miller et al., 1995; Murphy et al., 1984; Nelson & Neufeldt, 1996; Patterson, 1984). Less effective therapists are found to have lower levels of empathic understanding (Lafferty et al., 1989; Lambert & Bergin, 1994). Also, when clients feel understood by their therapists, positive change is promoted (Cooley & Lajoy, 1980). The important point here is that the clients' perceptions of empathy is most highly correlated with therapy outcome, not the therapists' perceptions of whether empathy is present (Cooley & Lajoy, 1980; Lambert & Bergin, 1994; Miller et al., 1995).

The last building block is respect. Respect was seen as a crucial element for building an effective therapeutic relationship. Clients were respected for who they were as people and for the qualities they possessed. Furthermore, the choices clients made were respected. The significance of respect in the therapy relationship is well documented (Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Miller et al., 1995; Nelson & Neufeldt, 1996; Patterson, 1980; Strupp et al., 1964). Nelson and Neufeldt highlighted the belief that clients are the experts on their own healing and that their choices should be respected: "Whether the concern is level of directiveness in counselling or type of interpretation to adopt, counsellors should provide their clients with the power to choose what will and will not work for them" (p. 613).

Threads That Bind.

The third part of the proposed framework involves the threads that bind. The threads that bind an effective therapeutic relationship together include safety and trust, maintaining the client's needs as focus, the therapist remaining available, achieving containment and closure, rediscovering the client's voice, and ensuring therapist integrity. These threads are aspects of the therapeutic relationship which are constantly present and which were seen by participants as having considerable influence on the effectiveness of therapy.

In the present study, safety and trust were identified by both the clients and therapists as an important thread. Research suggests that clients experience an increased sense of trust, safety, and security--which leads to the client viewing the problem differently and, ultimately, to the client acting differently--when common factors such as a strong therapeutic alliance, warmth, respect, empathy, and acceptance are present (Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996). In addition, research supports the significance of trust in the therapeutic relationship since one of the qualities present when strong alliances are formed is that the client perceives the therapist as trustworthy (Miller et al., 1995).

Another thread seen as critical by both clients and therapists was the necessity of maintaining the clients' needs as the focus. This involved the therapist being flexible and available, accessing other resources, and being willing to let the client set the pace of therapy. Support for the significance of maintaining the client's needs as the focus is seen by the recommendations that the therapist remain open and flexible, use other resources, be respectful when clients are resistant, and continually ask clients about the usefulness of the process (Nelson & Neufeldt, 1996). Lambert and Cattani-Thompson (1996) suggested that it is the therapist's responsibility to evaluate the suitability of clients for the interventions they offer and to access community resources in order to meet client's needs. Miller et al. (1995) argue for seeking the opinions of clients when assessing effectiveness of therapy--find out from the clients what is helpful for the clients.

Two threads that were identified only by the clients include the therapist being available and the need for containment and closure. Both are seen by clients as crucial threads that bind the therapy relationship together. It is common knowledge within clinical literature that the therapist being available is important to the client and that proper closure on issues that surface is essential (Courtois, 1988; Dolan, 1991). However, it appears that research regarding the effectiveness of psychotherapy rarely mentions these factors.

An important thread identified only by the therapists is the need to rediscover the client's voice. That is, therapists encouraged empowerment and provided opportunities for clients to have choice, control, and power in the relationship. Cooley and Lajoy (1980) suggested that those behaviours which therapists viewed as increasing the clients' autonomy and responsibility for their own behaviour and decreasing dependence are likely to be associated with positive outcomes in therapy. Interestingly, in the study by Cooley and Lajoy, client ratings of therapists encouraging independence were not associated with improvement. This suggests that both in the study by Cooley and Lajoy and in the present study, clients may be encouraged to become more independent without their becoming aware that this is a goal or direction of the therapy. Cooley and Lajoy concluded that "client and therapist views of certain aspects of the relationship, such as the Independence-Encouraging dimension, may conflict because of their differing roles in therapy" (p. 570). In addition, other researchers address the importance of empowering clients or supporting them to find their voice (Miller et al., 1995; Nelson & Neufeldt, 1996).

A second thread identified only by therapists as important to the effectiveness of counselling was the need for therapists to have integrity. The necessity of therapist integrity is well documented in research literature (Gelso & Carter, 1994; Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Miller et al., 1995; Nelson & Neufeldt, 1996). For example, it is recommended that therapists work on their own self-concept, pursue self-awareness, know their limits and refer a client who presents issues beyond their knowledge and ability level, inform clients of their rights and responsibilities, and keep informed by seeking out current research in the field (Nelson & Neufeldt, 1996).

Healing Through Relationship.

Healing through relationship composes the fourth dimension of a therapeutic relationship. In the present study, healing was described as happening through the relationship in several ways: the relationship acted as a first opportunity for clients to experience many new things, the therapist acted as a bridge, healing occurred through interaction, the therapist acted as a role-model, and the therapist acted as a guide. While these are new descriptions for conceptualizing the process of healing that occurs through the therapy relationship, the idea that it is through the therapeutic relationship that healing occurs is not new.

Within the research literature, the idea that healing occurs by the therapy relationship acting as a first opportunity for clients is evident by examining which aspects of the therapy have been identified as helpful. Having the opportunity to self-disclose or talk openly (Carver et al., 1989; Elliott & James, 1989; Hill et al., 1988), to feel understood (Carver et al., 1989; Murphy et al., 1984), to learn to take responsibility for one's life (Wheeler et al., 1992), and to engage in self-exploration (Lietaer, 1992; Martin & Stelmaczonek, 1988) have all been associated with effective therapy.

Therapists in this study were characterized as acting as bridges in several ways: by doing things for clients--such as nurture, respect, and believe in--until clients were able to do those things for themselves; by "reparenting" clients--replacing early negative messages with positive ones; by representing hope for a better future and thereby providing clients with the ability to get through difficult times; and, by supporting each client's connection with herself--to her own thoughts, feelings, and body sensations. Finding literature directly relating the idea of bridging as it is conceptualized here to the effectiveness of therapy is difficult. However, evidence for the ways in which participants in the present study described bridging to have occurred is ample. For example, bridging is facilitated when the therapist asks thoughtful questions (Lietaer, 1992), offers reassurance and encouragement (Elliott & James, 1989; Lietaer, 1992; Llewelyn et al., 1988), and provides continual validation (Armsworth, 1989; Hill et al., 1988; Hill et al., 1989). The role of the therapist has been likened to that of a midwife who, through relationship, helps the client give birth to him or herself (Elliott, 1983).

Healing through interaction occurred for participants in the present study when clients issues surfaced in the therapeutic relationship and then were able to be resolved and when clients applied what they learned in the relationship with the therapist to relationships outside of therapy. The process of past issues surfacing within the therapeutic relationship is usually referred to as transference which is "the repetition of past conflicts with significant other, such that feelings, attitudes, and behaviours belonging rightfully in those earlier relationships are displaced onto the therapist" (Gelso & Carter, 1994, p. 297). Numerous researchers have discussed the role that transference plays in therapy (Gelso & Carter, 1985, 1994; Luborsky, Barber & Crits-Christoph, 1990), and, in particular, the need for transference to be accompanied by eventual client awareness or insight in order for it to be a positive aspect of therapy (Gelso & Carter, 1994). However, the idea of healing through interaction goes beyond simply focusing on the dynamics of transference. It also emphasizes that growth occurs through a variety of interactions within the therapeutic relationship (Butler & Strupp, 1986) and that the learning that occurs within sessions can be generalized to relationships outside of therapy (Patterson, 1984).

Another way in which healing occurred through the relationship was by the therapists acting as role-models. The therapist acting as a role-model is another aspect that, while it is commonly identified as helpful in clinical literature (Courtois, 1988; Dolan, 1991; Stuhlmiller, 1994), it is not well-represented in research on the effectiveness or outcome of therapy.

The final way in which participants in this study described how healing occurred through the therapeutic relationship was by the therapist acting as a guide. Considerable research has characterized various guiding behaviours by therapist as helpful or effective. For example, helpful guiding or facilitative behaviours identified included generating insight and self-understanding (Bonney et al., 1986; Elliott & James, 1989; Fuller & Hill, 1985; Lietaer, 1992; Llewelyn et al., 1988; Wheeler et al., 1992), offering encouragement and reassurance (Elliott & James, 1989; Fuller & Hill, 1985; Hill et al., 1988; Llewelyn et al., 1988), giving advice (Lambert & Bergin, 1994; Murphy et al., 1984), summarizing and paraphrasing (Hill et al., 1988), thoughtful questioning (Miller et al., 1995), and generating solutions to problems (Martin & Stelmaczonek, 1988).

Rewards of the Experience.

The final dimension of the framework conceptualizing the therapeutic relationship involves rewards of the experience. Participants in the present study identified several rewards that resulted from the experience of being in therapy: the development of a cherished relationship, client healing, and therapist growth. Support for all of these aspects can be found in research literature. Perhaps one of the most highly recognized aspects of effective therapy is the development of a significant or cherished relationship or bond between the client and therapist (Gelso & Carter, 1985, 1994; Horvath & Symonds, 1991; Lambert & Cattani-Thompson, 1996; Mahrer & Nadler, 1986; Miller et al., 1995; Nelson & Neufeldt, 1996; Patterson, 1984). It is important to note that while such a bond exists at the end of therapy--and, this bond was considered to be one of the rewards of therapy by participants in the present study--it is believed that the relationship develops throughout therapy and is part of what contributes to effective therapy (Bordin, 1979).

Client healing as a result of the therapeutic relationship is seen to go beyond the removal of specific symptoms. Rather, psychotherapy has been described as an educational or re-educational process that effects many areas of the client's life (Strupp et al., 1964). In terms of client growth, research indicates that therapy is effective and that at the end of treatment, the average client receiving treatment is better off that 80 percent of people with a similar difficulty who did not receive treatment (Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996; Miller et al., 1995). Furthermore, research suggests that many clients achieve healthy adjustment for long periods of time (Lambert & Bergin, 1994; Lambert & Cattani-Thompson, 1996).

The therapist growth that results from being in a therapy relationship with a client is influenced by many factors such as the individuals involved and the presenting issues. For example, in the present study, one therapist described considerable growth that resulted from her being challenged to address her own beliefs around spirituality, yet for the other client-therapist dyads growth through exploring spiritual beliefs was not identified as a benefit. Although research regarding therapist growth through the counselling relationship is limited, it is an aspect that receives acknowledgement within clinical literature (Dolan, 1991).

Similarities in Client and Therapist Perceptions.

One of the aims of this research was to explore how well clients' and therapists' perspectives matched. For the participants in this study, there were many similarities between clients' and therapists' perceptions regarding what made therapy effective. Both clients and therapists described five overall aspects of therapy that contributed to its effectiveness: a healing foundation, building blocks, threads that bind, healing that occurs through relationship, and rewards of the experience. Although many of the client and therapist themes were similar, these similarities often came out of descriptions that were very different on the content level. For example, at the content level one client described the use of hypnosis during therapy sessions while another identified the use of drawing; however, at a deeper level, what the clients emphasized were qualities such as trust, safety, respect, and encouragement. Thus, the strategies or interventions often differed at a content level, but the participants' emphasis was always that these activities occurred within the context of a therapeutic relationship. The significance of the role of a positive therapy relationship was a constant theme for all of the participants.

These similarities in perceptions--that the therapeutic relationship is important and that this relationship is comprised of five main aspects (a healing foundation, building blocks, threads that bind, healing that occurs through relationship, and rewards of the experience)--are consistent with research which has suggested that often clients and therapists identify the same *general* or *overall* categories as helpful (Hill et al., 1989; Martin & Stelmaczonek, 1988; Thompson & Hill, 1991). However, it is important to note that although participants identified similar *overall* categories, often there were differences in how clients and therapists described each category and which aspects they emphasized.

Differences in Client and Therapist Perceptions.

As mentioned above, clients and therapists in the present study were found to have similar perceptions regarding *overall* influences that contribute to effective therapy. Within the overall categories that clients and therapists identified as helpful or effective, however, there were many notable differences. For example, a crucial thread identified by therapists in this study was the therapists' intent to assist clients in rediscovering their voice. However, clients did not place as much importance on this aspect of therapy. Similarly, clients stressed their view that knowing the therapist was available to them between sessions was a major contribution to the effectiveness of therapy. Therapists, on the other hand, did not seem to place much emphasis on the influence that their being available may have had on the effectiveness of therapy.

The notion that clients and therapists have differing perceptions regarding the therapy process and its effectiveness is well documented (Bonney et al., 1986; Caskey et al., 1984; Cooley & Lajoy, 1980; Dill-Standiford et al., 1988; Fuller & Hill, 1985; Horvath & Symonds, 1991; Lambert & Bergin, 1994; Miller et al., 1995). It has been suggested that discrepancies in perceptions demonstrate that clients and therapists view the relationship differently, perhaps because of their differing roles in therapy (Cooley & Lajoy, 1980). Since differences in perceptions between clients and therapists are well documented, the present study explored effective therapy experiences from the perspectives of both clients and therapists.

Final Reflections on the Data.

The participants in this study offer some new ways of conceptualizing the therapy experience. While the framework is new, many of the ideas described by it have substantial support within existing research literature. From the present study, one of the clearest messages from clients' and therapists' descriptions of their experiences is a message we have heard before: effective therapy is related to an effective client-therapist relationship. Through its descriptive and exploratory approach, this present study has offered a window into the therapeutic relationship from the perspectives of both clients and therapists.

Implications for the Treatment of Childhood Sexual Abuse

The findings of this study have practical implications for the treatment of childhood sexual abuse. First, this study offers insight into the therapy process with survivors of childhood sexual abuse. Secondly, this study highlights the importance of a positive therapeutic relationship in the treatment of childhood sexual abuse. And finally, it draws attention to the necessity of therapists to clarify their perceptions with clients and to not make assumptions without feedback from clients.

An important contribution of this study is that it offers research specifically related to therapy with survivors of childhood sexual abuse. This is significant since the vast majority of research regarding the effectiveness of therapy has involved studies based on the treatment of issues such as career choices, anxiety, and depression. In addition, much of the existing research has been based on counselling relationships that have been relatively short term. The treatment of sexual abuse, however, frequently requires long-term therapy (Feinauer, 1989). Thus, this study expands upon existing research by providing information specifically related to the treatment of survivors who have been in long-term therapy relationships.

A second implication of this study for the treatment of childhood sexual abuse survivors is that it highlights the important features of the therapeutic relationship in effective therapy. This study has provided a new way of conceptualizing the experience of effective therapy with survivors of childhood sexual abuse. The resulting framework describes important aspects of effective therapy from the beginning of the therapeutic relationship to its end. The framework, which was developed from participants' descriptions, offers guidance as to what constitutes an effective therapy relationship. For example, an effective therapeutic relationship is described as involving unconditional acceptance, continual validation, sincere compassion, and respect. Furthermore, by referring to this framework, therapists can assess their own approach to working with survivors: Are the various components, which were described by clients and therapists as important, present in my approach to therapy with survivors of childhood sexual abuse?

A final implication of this research for the treatment of survivors of childhood sexual abuse is that it demonstrates the need for therapists to clarify their perceptions with clients. Clients and therapists in this study had differing perceptions regarding the emphasis placed on certain components of the therapy process. For example, clients identified therapists being available and therapists facilitating closure on issues that surfaced as crucial elements of effective therapy. Therapists, on the other hand, mentioned these aspects only indirectly and placed more emphasis on the significance of empowering clients and on maintaining therapist integrity. Clearly, if therapists and clients have different experiences and perceptions of what is important in therapy, it is crucial for therapists to inquire as to how clients are experiencing the therapy process.

Limitations of This Study

The purpose of this research was to gain an understanding of clients' and therapists' perceptions of what constitutes effective therapy with childhood sexual abuse survivors and to explore how the perspectives compared to one another. For this research, the qualitative method of existential or hermeneutical phenomenology was chosen. However, due to the method and research design used, this study has several limitations.

One weakness of this study is that the validity of the data is limited. In order to understand the meaning of the participants' experiences in therapy, clients and therapists were interviewed and asked to describe their experiences in effective therapeutic relationships. While this method of collecting data enables the researcher to gain an understanding of a person's experience, it has several limitations. Since participants' descriptions are based on recalling their experience, these descriptions are subject to distortions such as forgetting information and interpreting or describing the experience based on one's current understanding rather than on one's understanding at the time the event occurred. Also, the participants may have edited or altered their descriptions as they recounted them to the researcher. Efforts were made to minimize the amount of editing that occurred by interviewing each participant individually before interviewing the client-therapist dyads together.

An additional concern regarding the validity of the participants' descriptions is that, despite attempts to keep the interviews open-ended so that participants could freely explore their experiences, the descriptions may have been influenced by comments made by the researcher during the interview. However, since one of my presuppositions was that the therapeutic relationship was important in the therapy process, extra care was taken to ensure that questions and probes during the interviews were not aimed at eliciting information regarding the relationship. Rather, questions focused on specific sessions, stages of therapy, and turning points. A further limitation of relying on data from participants' descriptions is that there is an inherent assumption that the kind of therapy that clients and therapists feel is most effective is in fact most effective in all areas at producing change. The existential phenomenological method accepts these risks of inaccuracy in order to gain the benefit of being able to explore a person's experience directly.

Another limiting factor in this research design was the method of participant selection. Participants were chosen by finding therapists who met the necessary criteria and who indicated interest in being involved in the research. Then, each therapist selected a client whom the therapist deemed appropriate for the study. This method of selecting participants is inherently biased since it involves interested therapists selecting interested clients.

The limitations due to the process of selecting participants are compound since only three client-therapist dyads were involved and the participants formed a relatively homogenous group--all the participants were women over the age of 43, all of the therapists were experienced, all of the clients had been severely abused by multiple offenders, and all of the dyads had worked together for a minimum of three years. Since all of the clients had experienced extensive abuse by multiple offenders and had been involved in long-term therapy, it may be that the participants in this study represent a special or unique population. For example, when the abuse has been less severe or when the therapy has been of a shorter duration, it may be that aspects such as transference and the role of re-parenting are less important in therapy. Because of these limitations regarding the selection and inclusion of participants, the generalizability of this research is severely compromised.

In order to address some of the concerns regarding the generalizability of the results, the researcher presented a summary of the participants' descriptions to six therapists and six clients who had not been involved in the study and invited them to comment on how closely the conceptualization of effective therapy fit with their own experiences. Feedback from these clients and therapists suggested that, overall, the descriptions were consistent with the experiences of the clients and therapists initially involved in the study. Generalizability could have been improved further by interviewing additional client-therapist dyads, especially ones involving males as the client, the therapist or both. However, being able to generalize the findings was not the intent of this study. Rather, the intent was to gain insight into the experience of being in therapy for the treatment of childhood sexual abuse so that therapists would be better able to support survivors on their healing journey. In achieving this goal, this research was successful.

Implications for Future Research

This study has offered insight into the effective treatment of childhood sexual abuse and, in doing so, has several implications for the direction of future research in this area. One implication is that the methodology chosen here, while it has limits, has much to offer when researching the therapy process. Qualitative research, specifically existential phenomenology, offers a way to explore and understand the meaning which people ascribe to phenomena which they experience. I believe that further qualitative studies would provide additional insight into what constitutes effective therapy with survivors of childhood sexual abuse. In addition, the inclusion of client-therapist dyads resulted in a more complete understanding of the experience of being in therapy; thus, it is recommended that future research in this area continue to incorporate the perspectives of both clients and therapists.

Future research could seek to provide additional validation for the framework that resulted from the participants' descriptions by replicating this study, by asking additional clients and therapists to review the results, or by designing a questionnaire based on the results and subsequently surveying a larger population of therapists and clients.

The present study could be expanded upon by including a larger number of participants who have different characteristics than the clients and therapists involved in this study. For example, this study could be extended by including males, by including younger participants, by focusing on shorter therapy relationships, and by conducting interviews both while the client is still attending therapy and after therapy is completed. In addition, clients and therapists who are focused on issues other than the treatment of childhood sexual abuse could be interviewed to explore the degree to which this framework of effective therapy is able to be generalized to therapy focused on other issues.

An additional way in which future research endeavours could build upon this study is by more specifically exploring each of the areas identified by participants so that the framework that resulted from this study can be further refined and developed. For example, a study focused on the building blocks of unconditional acceptance, continual validation, sincere compassion, and respect may provide valuable insight as to how these qualities are conveyed by therapists, how clients know they are present, how the qualities develop, and whether they are inter-related. Such a study could implement a tape-recall procedure to stimulate clients' and therapists' recall of their experiences.

Concluding Remarks

At the beginning of this research study, my goal was to discover the essence of the experience of effective treatment when healing from childhood sexual abuse. After reviewing existing literature in this area, it became clear that research directly related to working with survivors of sexual abuse was limited and that clients' perspectives on what was effective were under-represented. Furthermore, it seemed to me that the research that did exist seemed to miss the complexity of the treatment process. As a result, I chose an existential phenomenological approach, which included the perspectives of both clients and therapists, in an attempt to describe and understand the complex phenomenon of the treatment process with survivors.

While one of my presuppositions was that the therapeutic relationship played a critical role in the treatment process, I do not believe that this interfered with the descriptions that participants provided. I carefully worded my questions and probes so that they did not intentionally elicit information supporting my belief that the therapeutic relationship was critical. My questions were focused on "stages" of therapy, "turning points", and specific "sessions". Nevertheless, the responses I received from participants continually reinforced the idea that the therapy relationship plays a crucial role in the effectiveness of therapy. Furthermore, the feedback I received from clients and therapists who were not among the original participants also reinforced the significance of the therapeutic relationship. Through this study, I have gained a deeper understanding of the importance of a positive therapeutic relationship and of the necessity to clarify my own perceptions with those of my clients. As I continue to grow as a therapist, I will embrace this understanding and insight.

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Appendix A

Letter to Therapist

Date
Inside Address

Dear (*therapist's name*):

As I explained in our telephone conversation, I am currently doing research titled **"Client and Therapist Perspectives on Healing from Childhood Sexual Abuse"**. The purpose of this study is to gather information about how clients and therapists view the counselling process for individuals who have been sexually abused. In particular, this project seeks to explore the clients' and therapists' perspectives on which issues are and are not being addressed in therapy and what aspects of counselling are most and least helpful. It is hoped that this information will enhance current treatment approaches for addressing issues related to childhood sexual abuse.

For this research, I am seeking dyads of therapists and clients who have worked together who would be willing to share their experiences with me. I am interested in counsellor-client dyads where,

the **therapist**:

-has a graduate degree (e.g., MEd, MSW, PhD)
-has at least five years of counselling experience
-belongs to a regulatory body (i.e., for psychologists, social workers, counsellors)
-works with survivors of childhood sexual abuse

and where the **client**:

- is at least 18 years old
- has at least one clear memory of childhood sexual abuse
- was abused by someone known to him/her (e.g., relative, family friend, teacher, coach, babysitter)
- was abused on more than one occasion
- was involved in therapy with you for at least 6 months
- experienced "success" in therapy
- has "completed" therapy (at least for now)

Thus, if you fit the description above and have a client who may be interested, **I invite you to become involved in this project**. I would be pleased to answer any of your questions in person or by telephone prior to any commitment of participation being made. Because this research is based on client-counsellor dyads, both client and counsellor must be willing to participate prior to any data collection occurring. During this study, each client and counsellor will be interviewed individually.

Participation in this study would involve three meetings, scheduled at your convenience:

1) a brief meeting to introduce the project, answer any questions, and obtain informed consent
2) an interview of approximately 60 minutes in length (to describe the experience of the counselling process)
3) a follow-up meeting to review the information gathered, check it for accuracy, and offer any additional information

This is a voluntary project and participants may withdraw at any time without penalty. The confidentiality and anonymity of all participants will be protected. However, as the research is based on counsellor-client dyads, it is important to note that each client will know that his/her therapist is participating and each therapist will know which client is participating. The confidentiality and anonymity of all participants will be protected by the use of pseudonyms. Each participant will be offered a copy of my thesis upon its completion.

I have **enclosed an introductory letter and a release of information form for you to distribute to clients** whom you believe may be suitable and interested in this research project. Please contact me at your earliest convenience to discuss your interest in participating in this study. I can be reached at **437-7524**. Thank you for considering involvement in this project. I look forward to hearing from you soon.

Sincerely,

Mary Pudmoreff
MEd Student in Counselling Psychology
University of Alberta

Dr. Barbara Paulson
Thesis Supervisor
University of Alberta

Appendix B

Letter to Client

March 18, 1996

Hello!

My name is Mary Pudmoreff and I am a Master's Student in the Counselling Psychology program at the University of Alberta. For my thesis, I am doing research titled **"Client and Therapist Perspectives on Healing from Childhood Sexual Abuse"**. The purpose of this study is to gather information about how clients and therapists view the counselling process for individuals who have been sexually abused. In particular, this study seeks to explore the clients' and therapists' perspectives on which issues are and are not being addressed in therapy and what aspects of counselling are most and least helpful. It is hoped that this information will enhance current treatment approaches for addressing issues related to childhood sexual abuse.

Your former therapist has expressed interest in this research and thought that you might also be interested in participating. For this research, I am seeking therapists and clients who have worked together who would be willing to share their experiences and perceptions with me. I am interested in exploring the therapy process for individuals who:

- are at least 18 years old
- have at least one clear memory of childhood sexual abuse
- have been abused by someone known to them (e.g., relative, family friend, teacher, coach, babysitter)
- have been abused on more than one occasion
- were involved in therapy for at least 6 months
- experienced "success" in therapy
- have "completed" therapy (at least for now)

Becoming involved in a study like this can be a way for you to reflect on the progress you have made in therapy and to contribute to the successful healing journey of many other survivors of sexual abuse. Because this research is based on client and counsellor perceptions, both client and counsellor must be willing to participate prior to any data collection occurring. During this study, each client and counsellor will be interviewed individually.

Participation in this study would involve three meetings, scheduled at your convenience:

1) a brief meeting to introduce the project, answer any questions, and obtain informed consent
2) an interview of approximately 60 minutes in length (to describe the experience of the healing process)
3) a follow-up meeting to review the information gathered, check it for accuracy, and offer any additional information

This is a voluntary project and participants may withdraw at any time without penalty. The confidentiality and anonymity of all participants will be protected. However, as the research is based on counsellor-client dyads, it is important to note that each client will know that his/her therapist is participating and each therapist will know which client is participating. The confidentiality and anonymity of all participants will be protected by the use of pseudonyms. Each participant will be offered a copy of my thesis upon its completion.

If you are willing to participate in this study or would like to learn more about this project, please sign the "Consent to Release Information" form and return it to your former therapist. Your therapist will then provide me with your name and phone number and I will contact you. If you would rather contact me directly, I can be reached at 437-7524. I would be pleased to talk with you by telephone or in person to answer any questions prior to any commitment of participation being made. Thank you for taking the time to consider becoming involved in this project. I look forward to hearing from you soon.

Sincerely,

Mary Pudmoreff
MEd Student in Counselling Psychology
University of Alberta

Dr. Barbara Paulson
Thesis Supervisor
University of Alberta

Appendix C

Consent to Release Information

I, ____, grant permission for my former counsellor, ________________________, to disclose information regarding myself and the therapy I received to Mary Pudmoreff for the purposes of her research project, "Client and Therapist Perspectives of Effective Treatment of Childhood Sexual Abuse". Only information relevant to the research project will be discussed and this consent is considered withdrawn once the project is completed.

______________________________ (client's signature)

____________________ (date)

______________________________ (witness)

Appendix D

Informed Consent Form

Client & Therapist Perspectives of Effective Treatment of Childhood Sexual Abuse

The purpose of this study is to gather information on clients' and therapists' perspectives of the treatment process for individuals who have been sexually abused as children. It is hoped that this information will enhance current treatment approaches for addressing issues related to childhood sexual abuse.

Participants may accept or decline to participate and are free to withdraw from the project at any time, without penalty. Participation in this project will involve an interview of approximately one-hour in length during which participants will be asked to describe their experience of what makes the treatment of childhood sexual abuse effective. The interviews will be audio-taped and the tapes will be transcribed with identifying information changed. Once the interview has been transcribed, the audio-tapes will be erased. After the interviews have been transcribed and the information analyzed, participants will be asked to participate in a second interview to review and comment on the information gathered. The confidentiality and anonymity of all participants will be protected through the use of pseudonyms.

It is recognized that this topic may create discomfort for some participants. The researcher will be available to participants for support and confidential referral if additional assistance is required. The results of this study will be used for Mary Pudmoreff's Master's thesis and may be used in subsequent professional publications and presentations.

I have an understanding of:

i) the purpose and nature of the project,
ii) the expected benefits,
iii) the tasks involved,
iv) the inconveniences and risks,
v) the identity of the researcher involved in the project,
vi) who will receive the information,
vii) how the information will be used,
viii) the right to give or withhold consent for participation,
ix) the right to withdraw at any time during the process,
x) how confidentiality will be maintained

I give my informed consent to participate in this project.

....	....	....
Date	Signature of Participant	Signature of Researcher

For more information, contact:

Mary Pudmoreff	Dr. Barbara Paulson
Principle Researcher	Academic Supervisor
University of Alberta	University of Alberta
492-3746 (school) 437-7524 (home)	492-5298 (office)

Appendix E

Interview Guide for Clients

1) What led you to seek counselling with _______?
   - *What issues were troubling you at the time?*
   - *How did you choose ______ to be your therapist?*

2) Tell me about the beginning stage of therapy, when you first started seeing______.
   - *How did you feel?* *-What did you think?* *-What were your first impressions?*
   - *At this stage, what contributed to counselling being successful? What was less helpful?*
   - *During this initial stage, what did you think ______ was feeling or thinking?*
   - *When did you know counselling would be helpful? How did you know this?*
   - *How did the early sessions compare with your expectations?*

3) Tell me about the middle stage of therapy with __, when most of the "work" was done.
   - *What did you feel?* *-What did you think?*
   - *At this stage, what contributed to counselling being successful?*
   - *What was less helpful?*
   - *During this middle phase, what do you think _____ was thinking and feeling?*

4) Describe one of the "turning points" in therapy.
   - *What made it a turning point? How did you feel?*
   - *What did you think? What did you do? What did _____ do?*

5) Tell me about a session you remember as "helpful" or "good" or "effective".
   - *How did you feel? What did you think? What did ______ do? What did you do?*
   - *Were there any exercises, techniques or interventions that seemed particularly helpful?*

6) Tell me about a session you remember as less helpful or less useful.
   - *How did you feel? What did you think? What did _____ do? What did you do?*
   - *Were there any exercises, techniques or interventions that were not helpful?*

7) Tell me about the ending stage of therapy.
   - *How was it decided that you would no longer attend counselling?*
   - *How did you feel?* *-What did you think?*
   - *At this stage, what contributed to counselling being successful?*
   - *What was less helpful?*

8) Overall, what do you think made the counselling you received useful or effective?
9) What do you think ______ would say made the counselling effective or useful?
10) Is there anything else that helped to make counselling effective or helpful for you?
11) Is there anything else that was not as helpful or effective for you?

Appendix F

Interview Guide for Therapists

1) Tell me about the beginning stage of therapy, when you first started seeing______.
   - *What were your first impressions?*
   - *What did you feel?* -*What did you think?*
   - *In this stage, what contributed to counselling being successful?*
   - *What was less helpful?*
   - *In the beginning, what do you think _____ was thinking and feeling?*

2) Tell me about the middle stage of therapy with __, when most of the "work" was done.
   - *What did you feel?* -*What did you think?*
   - *At this stage, what contributed to counselling being successful?*
   - *What was less helpful?*
   - *During this middle phase, what do you think _____ was thinking and feeling?*

3) Describe one of the "turning points" in therapy.
   - *What made it a turning point?*
   - *How did you feel?* -*What did you think?*
   - *What did you do?* -*What did _____ do?*

4) Tell me about a session with____you remember as "helpful" or "good" or "effective".
   - *How did you feel?* -*What did you think?*
   - *What did ______ do?* -*What did you do?*
   - *Were there any exercises, techniques, or interventions that seemed particularly helpful?*

5) Tell me about a session with _____you remember as less helpful or useful.
   - *How did you feel?* -*What did you think?*
   - *What did _____ do?* -*What did you do?*
   - *Were there any exercises, techniques or interventions that seemed less helpful?*

6) Tell me about the ending stage of therapy with _____.
   - *How was it decided that _____ would no longer attend counselling?*
   - *How did you feel?* -*What did you think?*
   - *At this stage, what contributed to counselling being successful?*
   - *What was less helpful?*

7) Overall, what do you think made the counselling with ______ useful or effective?
8) What do you think ______ would say made the counselling effective or useful?
9) Is there anything else that helped make the treatment effective or helpful?
10) Is there anything else that interfered with the treatment being effective or helpful?

Appendix G

Summary of Client Themes

I. HEALING FOUNDATION

Three aspects contribute to the foundation necessary for healing: the therapist being genuine, the client being motivated, and the therapy process being entered as a joint venture. These three aspects are present when entering therapy and they appear to be essential components for effective therapy when healing from childhood sexual abuse.

1. Therapist Being Genuine

   Therapists were seen by clients as "real" people who were invested and fully present during counselling sessions. Appreciation was expressed for the therapists' sharing of personal information through self-disclosure, for their direct and clear manner, and for their openness in accepting responsibility for their mistakes. In addition, clients described feeling as though they were treated as people rather than as appointments.

2. Client Being Motivated

   Another key ingredient for the foundation of the healing process involved the client being motivated. Clients described themselves as persistent, determined, motivated and committed.

3. Therapy--A Joint Venture

   Clients recognized therapy as a joint venture, a collaborative process in which both clients and therapists have contributions, responsibilities, and influence. Clients experienced a sense that the joint venture of therapy had a dynamic of its own (e.g., if you pass over an issue too quickly, it will come back up) and felt that it was necessary for the client and therapist to complement or match each other. Clients tended to attribute difficulties in the therapy relationship to themselves (e.g., not ready or able to hear it; misunderstood).

II. BUILDING BLOCKS

Clients identified four building blocks that are required for a positive therapeutic experience: unconditional acceptance, continual validation, sincere compassion, and respect. These qualities were seen as essential to having a positive or effective therapeutic experience. They build the supportive atmosphere and relationship necessary for healing to occur.

1. Unconditional Acceptance

   Clients identified the need for therapists to maintain an accepting, nonjudgemental, and open attitude at all times. Clients described how who they were, what they disclosed, and how they felt and behaved were all met with unconditional acceptance on the part of the therapists. In addition, clients expressed appreciation for the times when therapists conveyed acceptance through self-disclosing or story-telling which offered reassurance and normalized behaviours.

2. Continual Validation

   Clients expressed their strong need to be believed and to be validated. They appreciated having their experience believed as well as having who they were as people acknowledged and validated.

3. Sincere Compassion

   Sincere, genuine compassion was an essential building block for creating a supportive atmosphere. Such compassion includes empathy, understanding, support, patience, caring, warmth, and love.

4. Respect

   Clients described feeling respected by therapists. They felt respected for who they were as people and they felt their choices were respected. Such respect was fostered by clients being recognized as unique individuals and by their feeling of being treated as equals. Despite the inherent imbalance of power in the client-therapist relationship, clients were given power and control in the relationship. When clients mentioned respect, they described mutual respect. That is, in addition to feeling respected, clients expressed their respect for the therapists.

III. THREADS THAT BIND

With the healing foundation and building blocks in place, the beginnings of an effective therapy experience are established. The threads that bind all of these together are needed--threads which contain aspects of the relationship that are constantly present. For clients, these threads included safety/trust, the necessity for the clients' needs to remain as the focus, therapist availability, and containment and closure. These aspects weave in and out, building upon the foundation and tying the building blocks together.

1. Safety/Trust

   Safety and trust are seen as crucial for healing to occur in relationship.

2. Client's Needs as Focus

   Clients expressed the necessity of their needs being the focus of therapy. Clients described therapists as flexible--open to doing or using whatever would help clients to heal. In addition, clients recognized that pacing was geared to match their own needs.

3. Therapist Availability

   For clients, therapist availability was a crucial thread that ran throughout the therapy relationship. Clients described relying on and being dependent on the therapist. The therapist was often seen as a lifeline, as someone who stood by the client and who never abandoned her. There was comfort in knowing that the therapist was always there. Also, there was a sense that the therapist is still there, that she is still available.

4. Containment and Closure

   Closure was seen by clients as important. For clients, the need for containment or closure on issues that surfaced, on each session, and, on the therapeutic relationship, was seen as critical. Throughout therapy, containment and closure helped to minimize client vulnerability and supported efforts to celebrate healing or progress.

IV. HEALING THROUGH RELATIONSHIP

If therapy is entered with a strong healing foundation (i.e., therapist being genuine, client being motivated, and therapy viewed as a joint venture), and the building blocks are present (i.e., unconditional acceptance, continual validation, sincere compassion, and respect), and these are woven together throughout therapy with the threads that bind (i.e., safety/trust, client's needs as focus, rediscovering the client's voice, and therapist integrity), then, healing can occur through the therapeutic relationship.

Healing through the therapeutic relationship occurs in many ways: the relationship acts as a first opportunity for clients to experience many things, the therapist acts as a bridge, healing occurs through interaction, the therapist acts as a role-model, and the therapist acts as a guide.

1. First Opportunity To...

   Clients described feeling that it was in relationship with the therapist that they had their first opportunity to experience unconditional acceptance, continual validation, sincere compassion, respect, safety, and trust. It was within the therapy relationship that they first disclosed, were able to talk about the abuse, and were believed. It was the first opportunity they had to focus on their own feelings and needs, to feel as though they had an ally, and to develop a sense of hope. For the first time, clients experienced having power, choice, and control in a relationship.

2. Therapist as a Bridge

   Clients described how the therapist acts as a bridge--by doing things for the client until the client is able to do things for herself. For example, the therapist loves, nurtures, supports, cares for, respects, accepts, trusts, believes in, and values client even when she is unable to do those things for herself. Clients explained that the therapist also acts as a bridge by reparenting the client--by replacing early negative messages with positive ones. In addition, bridging occurred when clients thought about their therapist to help them cope during difficult times. And finally, the therapist acts as a bridge by supporting the client's connection to herself--to her own thoughts, feelings, and body sensations.

3. Healing Through Interaction

Clients recognized that healing opportunities occurred when their own issues surfaced in the therapeutic relationship and then were able to be worked through or resolved. For example, a client who is unable to appropriately express anger in most relationships becomes angry at the therapist and, through interacting with the therapist, learns how to manage or express her anger within the therapeutic relationship. In addition, clients described how they were able to apply what they learned by interacting with the therapist to other relationships.

4. Therapist Being a Role-model

Another way in which healing occurred through the relationship was by therapists acting as role-models for clients. For example, clients described consciously choosing the therapist as a role-model. In some instances, therapists had considerable impact and provided hope by self-disclosing and by being an example of how being a survivor and being emotionally healthy is possible. In addition, by participating in activities, therapists modeled safety, comfort, and openness.

5. Therapist Being a Guide

Therapists were considered guides. They were recognized as facilitating the process, deepening the experience, empowering clients, and generating insight. Some of the helpful therapist behaviours that clients identified as guiding their experience included questioning, probing, exploring, clarifying, challenging, and inviting; focussing, tracking, and monitoring; teaching, observing, listening, reflecting, summarizing, and directing; and, encouraging, nurturing, reassuring, normalizing, reinforcing, affirming, and valuing clients.

V. REWARDS OF THE EXPERIENCE

The experience of being in therapy led to both expected and unexpected rewards. Clients identified these rewards as developing a cherished relationship, client healing, and therapist growth.

1. Cherished Relationship

Each client described an immediate attraction to her therapist, a sense of "clicking", and a sense that fate brought them together. Clients viewed the relationship as real--there was a definite bond, a sense of human connectedness. Clients expressed feeling the relationship was unique and special. They felt grateful and expressed a sense of indebtedness to their therapists. Also, clients indicated that it was difficult to end the therapeutic relationship and that the relationship remained important even after therapy finished.

2. Client Healing

   Clients described how they developed understanding--they gained insight and faced past issues that were buried. Clients recognized their reconnection to themselves--they had learned to trust and value themselves, respect and nurture themselves, and recognize their own strengths and resources. They described regaining a sense of control that resulted in increased independence, the ability to manage their own lives, feeling strong, having choices, and developing healthier coping skills and clearer boundaries. And finally, clients described their reconnection to the community which was evident as they generalized their learning to other relationships, utilized outside resources, and began giving back to others.
3. Therapist Growth

   Clients described being aware that, throughout the therapeutic relationship, not only did they grow, but so did their therapists.

Comments and Consent

(To be Completed and Returned to Mary)

NOTE: Please answer these questions in regard your work with the therapist we discussed (not by referring to other therapists you may have seen or to therapy in general)

1) Does the information presented here reflect your experience of working with the specific therapist that we discussed? (Does this summary seem to "fit" with your experience?)

2) Is there anything in this description that does not reflect your experience? (Does anything seem inaccurate or false?) (If yes, explain)

3) Is there anything missing from this description that you feel was an important aspect? (Have I missed a crucial piece?) (If yes, explain)

4) Would you like a copy of my thesis when it is completed?

CONSENT FORM:

I am aware that quotations from my interview will be used in writing this thesis and possible subsequent publications. I understand that my name and any identifying information will be changed. However, I also understand that, although my identity will be confidential, it is possible that my therapist may be able to recognize some of the statements regarding her. I understand this risk and give my consent for quotations to be used. I also understand that, if I choose, I have the right to request an opportunity to review my transcript and indicate which quotations I would like not to be used.

____________	____________	____________
Date	**Signature**	**Name (please print)**

Appendix H

Summary of Therapist Themes

I. HEALING FOUNDATION

Three aspects contribute to the foundation necessary for healing: the client being motivated, the therapist being genuine, and the therapy process being entered as a joint venture. These three aspects are present when entering therapy and they seem to be essential components for effective therapy when healing from childhood sexual abuse.

1. Client Being Motivated

   Therapists saw clients as determined, motivated, and committed. They described the clients as courageous, strong, and active in healing process.
2. Therapist Being Genuine

   Therapists described themselves as honest, open, and sincere. They talked about being genuine and sharing their own experiences and feelings.
3. Therapy--A Joint Venture

   Therapists recognized therapy as a joint venture, a collaborative process in which both clients and therapists have contributions, responsibilities, and influence. Therapists displayed trust in the therapy process and recognized that they complemented their clients. Therapists tended to attribute difficulties in therapy to the therapy process or to themselves.

II. BUILDING BLOCKS

Therapists identified four building blocks that are required for a positive therapeutic experience: unconditional acceptance, continual validation, sincere compassion, and respect. These qualities were seen as essential to having a positive or effective therapeutic experience. They assist in building the supportive atmosphere and relationship necessary for healing to occur.

1. Unconditional Acceptance

   Therapists emphasized the necessity of feeling unconditional acceptance for the client. This involved an accepting, nonjudgemental, and open attitude at all times. This acceptance was conveyed through maintaining a nonjudgemental attitude, believing the client, and being spontaneous and genuine.
2. Continual Validation

   Believing, acknowledging, valuing, affirming, encouraging and validating the client was seen as critical.
3. Sincere Compassion

   Therapists viewed genuine compassion as essential. This includes empathy, understanding, support, patience, caring, warmth, and love. Therapists described how their compassion was reflected by their commitment, their believing the client, their listening and understanding, and their caring.

4. Respect

   Each therapist emphasized how much she respected her client. There was respect for who the client was as a person and for the qualities she displayed. Therapist's respect was evident by honouring client choices, viewing the client as an expert on her own healing, and believing the client has all the resources she needs to heal.

III. THREADS THAT BIND

With the healing foundation and building blocks in place, the beginnings of an effective therapy experience are established. The threads that bind all of these together are needed--threads which contain aspects of the relationship that are constantly present. For therapists, these threads included safety/trust, the necessity for the clients' needs to remain as the focus, rediscovering the client's voice, and maintaining therapist integrity. These aspects weave in and out, building upon the foundation and tying the building blocks together.

1. Safety/Trust

   Safety and trust are seen as crucial for healing to occur in the therapeutic relationship. The therapist emphasizes her own obligation to be trustworthy.

2. Client's Needs as Focus

   Within the therapy relationship, client needs are seen as paramount. To meet client needs, therapists were flexible, available, open to other resources, and willing to let the client set the pace.

3. Rediscovering Client's Voice

   Therapists made conscious efforts to help clients find their own voice. That is, therapists encouraged empowerment and gave clients choice, control, and power in the relationship. Emphasis was placed on connecting clients with their own thoughts, feelings and beliefs. Effort was made not to rescue or unduly influence clients.

4. Therapist Integrity

   For therapists, one of the threads that ran throughout the counselling relationship was the imperativeness of therapist integrity. Therapists emphasized the need to be aware of their own issues, characteristics, and limits. Concerns such as ongoing self-exploration and self-awareness, accepting responsibility, making appropriate referrals, and seeking necessary consultation were identified.

5

IV. HEALING THROUGH RELATIONSHIP

If therapy is entered with a strong healing foundation (i.e., client being motivated, therapist being genuine, and therapy viewed as a joint venture), and the building blocks are present (i.e., unconditional acceptance, continual validation, sincere compassion, and respect), and these are woven together throughout therapy with the threads that bind (i.e., safety/trust, client's needs as focus, rediscovering the client's voice, and therapist integrity), then, healing can occur through the therapeutic relationship.

Healing through the therapeutic relationship occurs in many ways: the therapist acts as a bridge, the relationship acts as a first opportunity for clients to experience many things, healing occurs through interaction, the therapist acts as a role-model, and the therapist acts as a guide.

1. Therapist as a Bridge

Therapists described many ways in which they acted as "bridges" for clients. Often therapists acted as bridges by doing things for clients until the clients were able to do those things for themselves. For example, the therapists cared for, loved, nurtured, supported, respected, accepted, trusted, believed in, and valued clients when clients were unable to do those things for themselves. Therapists also acted as a bridge by reparenting clients. That is, they worked to replace old, unhealthy messages with more positive ones. And, they encouraged clients to parent or reparent themselves. And finally, therapists described how they acted as a bridge by supporting clients in developing healthier coping mechanisms and in healing past pain.

2. First Opportunity To...

Therapists identified the importance of the therapy relationship as providing many first opportunities for clients. For example, therapists described how their relationship with clients was the first opportunity for clients to view themselves as people who were valuable and worthwhile. Also, therapists highlighted that the therapeutic relationship was the first opportunity for clients to identify and examine many issues.

3. Healing Through Interaction

Therapists identified that healing opportunities occurred when clients' issues surfaced in the therapeutic relationship and were then able to be worked through or resolved. For example, a client who is unable to appropriately express anger in most relationships becomes angry at the therapist and, through interacting with the therapist, learns how to manage or express her anger within the therapeutic relationship. In addition, therapists described how clients were able to apply what they learned by interacting with the therapist to other relationships. Another way in which healing through interaction occurred involved transference--when clients projected feelings connected to other relationships onto the therapist. By being able to work through these issues with the therapists, clients were able to heal and grow.

4. Therapist Being a Role-model

   Therapists described how they acted as role-models for client by modelling things like self-care, self-acceptance, valuing self, and healthy expression anger. At times, therapists expressed concern that their influence may have been more than desired.

5. Therapist Being a Guide

   Therapists facilitated the process, deepened the experience, empowered clients, generated insight, and connected clients with themselves. Some of the ways in which they did this included guiding, facilitating, supporting, observing, reframing, inviting, tracking, monitoring, and focussing the client.

V. REWARDS OF THE EXPERIENCE

The experience of being in therapy led to both expected and unexpected rewards. Therapists identified these rewards as developing a cherished relationship, client healing, and therapist growth.

1. Cherished Relationship

   Each therapist viewed the relationship with her client as cherished. There was a sense of realness and human connectedness. Each therapist expressed liking the client. Therapists and clients complemented each other and the relationship was seen as unique. Therapists recognized the significance of the therapy relationship and remained available to the clients after closure.

2. Client Healing

   Therapists viewed clients as having grown in many ways. Clients developed a greater understanding about the past--they gained insight and faced past issues that were buried. Clients were seen as having reconnected to themselves. That is, they had learned to trust and value themselves, respect and nurture themselves, and recognize their own strengths and resources. Clients were also described as having regained control over their lives which resulted in clients gaining independence, appearing stronger, recognizing that they had choices, and developing healthier coping skills and clearer boundaries. And, finally, therapists described how clients reconnected to the community by generalizing their learning to other relationships, utilizing outside resources, and giving back to others.

3. Therapist Growth

   Therapists described themselves as having grown both personally and professionally through the relationship. This growth included gaining insight, learning new skills, gaining experience, learning from mistakes, and exploring personal values and beliefs.

Comments and Consent

(To be Completed and Returned to Mary)

NOTE: **Please answer these questions in regard to the specific client we discussed** (not by referring to clients or therapy in general)

1) Does the information presented here reflect your experience of working with the specific client that we discussed? (Does this summary seem to "fit" with your experience?)

2) Is there anything in this description that does not reflect your experience? (Does anything seem inaccurate or false?) (If yes, explain)

3) Is there anything missing from this description that you feel was an important aspect? (Have I missed a crucial piece?) (If yes, explain)

4) Would you like a copy of my thesis when it is completed?

CONSENT FORM:

I am aware that quotations from my interview will be used in writing this thesis and possible subsequent publications. I understand that my name and any identifying information will be changed. However, I also understand that, although my identity will be confidential, it is possible that the client I discussed will be able to recognize some of the statements regarding her. I understand this risk and give my consent for quotations to be used. I also understand that, if I choose, I have the right to request an opportunity to review my transcript and indicate which quotations I would like not to be used.

Date	Signature	Name (please print)

Appendix I

Description of Client Themes

The Client's Experience of Being in Therapy

	First and Second Order Themes	Generalized Description
I.	Healing Foundation	
	1. Therapist Being Genuine	Therapist seen by client as "real" and fully present. Therapist self-disclosed and shared personal information. Client treated as a person not an appointment. Therapist was direct, clear, and open and accepted responsibility for mistakes.
	2. Client Being Motivated	Client recognized self as persistent, determined, motivated, and committed; sense of being "driven to heal".
	3. Therapy--A Joint Venture	Therapy process recognized as a collaborative process; both client and therapist seen as having contributions, responsibilities, and influence. Client and therapist complement each other. Joint venture has a dynamic of its own. Client tended to attribute difficulties in therapy to self.
II.	Building Blocks	
	1. Unconditional Acceptance	Acceptance, nonjudgementalness, and openness crucial to building a supportive relationship. Who client was, what she disclosed, and how she felt were accepted unconditionally. Reassurance was offered and behaviours were normalized.

2. Continual Validation	Being believed, acknowledged, valued, affirmed, encouraged and validated seen as critical. It was important to have experiences believed and who they are as people validated.
3. Sincere Compassion	Genuine compassion essential; includes empathy, understanding, support, patience, caring, warmth, and love.
4. Mutual Respect	Respect fostered by a sense of equality, by client being recognized as unique individual, by client having power and control in the relationship. Client felt respected for who she was and felt that her choices were respected. Client also respected the therapist.
III. Threads That Bind	
1. Safety/Trust	Safety and trust seen as crucial for healing to occur in relationship; fostered by therapist being attentive, ensuring self-care, having clear boundaries, and demonstrating strength.
2. Client's Needs as Focus	Client needs seen as paramount. Therapist flexible, open and willing to use whatever resources will help client. Pacing to match client needs.
3. Therapist Availability	Therapist availability seen as crucial; client relied on and was dependent on therapist; therapist seen as "lifeline"; therapist stood by and never abandoned client; therapist remains professionally available even after closure.
4. Containment and Closure	Closure on issues, on each session, and on therapeutic relationship seen as essential; containment; closure minimized client vulnerability and celebrated healing.

IV. Healing Through Relationship

1. First Opportunity To...	Therapeutic relationship first opportunity for client: to experience acceptance, validation, compassion, respect, safety, and trust; to disclose, talk openly, and be believed; to focus on own feelings and needs, to have an ally, and to develop hope; to have power, choice and control in a relationship.
2. Therapist as a Bridge	Therapist does for client until client able to do for self; therapist reparents client by replacing early negative messages with positive ones; thoughts of therapist help client cope; therapist supports client's connection to self.
3. Healing Through Interaction	Client's own issues surface in the therapeutic relationship and are able to be worked through; client resolves issues in relationship with therapist and then generalizes this learning to other relationships; healing through role-playing.
4. Therapist Being a Role-model	Therapist acts as role-model for client; client consciously chose therapist as role-model; therapist models participation in activities; therapists model emotional health and clear boundaries.
5. Therapist Being a Guide	Therapist facilitates process, deepens experience, fosters empowerment, generates insight, and connects client with self. Therapist challenges client's perspective, tracks progress, clarifies issues, encourages progress, and teaches new skills.

V. Rewards of the Experience

1. Cherished Relationship	Relationship is seen as cherished; an immediate attraction and "clicking"; a "real" relationship--a bond, a sense of human connectedness; client felt relationship was unique and special; sense that fate brought them together; client felt grateful and indebted. Relationship remains important after closure.
2. Client Healing	Client heals in many ways: develops understanding, reconnects to self, regains control, and reconnects to community.
3. Therapist Growth	Therapist seen as growing both personally and professionally through the relationship; therapist gained confidence, insight, experience, and skills.

Appendix J

Description of Therapist Themes

The Therapist's Experience of Being in Therapy

	First and Second Order Themes	Generalized Description
I.	Healing Foundation	
	1. Client Being Motivated	Client seen as determined, motivated, and committed; also as courageous, strong, and active in healing process.
	2. Therapist Being Genuine	Therapist sees self as honest, open, sincere, and genuine. Therapist shares own feelings and experiences.
	3. Therapy--A Joint Venture	Therapy process recognized as a collaborative, joint process; both client and therapist seen as having contributions, responsibilities, and influence; therapist complements client and displays trust in the therapy process; therapist tends to attribute difficulties in therapy to the process or to self.
II.	Building Blocks	
	1. Unconditional Acceptance	Acceptance, nonjudgementalness, and openness seen as crucial. Acceptance conveyed through maintaining a nonjudgemental attitude, believing the client, and being spontaneous and genuine.
	2. Continual Validation	Believing, acknowledging, affirming, encouraging and validating the client seen as critical.
	3. Sincere Compassion	Genuine compassion essential; reflected by commitment, believing the client, listening, understanding, and caring.

4. Respect	Respecting client for who she is and for the qualities she displays. Respect uniqueness of each client. Respect evident in honouring client choices, viewing client as expert on own healing, and believing client has resources needed to heal; equality emphasized.
III. Threads That Bind	
1. Safety/Trust	Safety and trust seen as crucial for healing to occur in relationship; fostered through reassurance, respecting client, having clear boundaries, and demonstrating strength; therapist emphasizes own obligation to be trustworthy.
2. Client's Needs as Focus	Client needs seen as paramount. To meet client needs, therapists were flexible, available, open to other resources, and willing to let client set the pace.
3. Rediscovering Client's Voice	Emphasis on supporting client to find their own voice; encouraged empowerment and provided opportunities for clients to have choice, control, and power; endeavours to connect client with own thoughts, feelings and beliefs; efforts not to rescue or unduly influence client.
4. Therapist Integrity	Therapist integrity imperative. Emphasis on need to be aware of own issues, characteristics, and limits. Therapist valued self-awareness, accepting responsibility, making appropriate referrals, and seeking consultation. A need for responsible, ethical and clear boundaries.

IV. Healing Through Relationship

1. Therapist as a Bridge	Therapist does for client until client able to do for self (loves, cares for); therapist as a bridge to hope; therapist as a bridge to the community; therapist "reparents" client by replacing early negative messages with positive ones through reassurance, encouragement, and validation; therapist acts as bridge by being an intermediary step for client when client develops healthier coping mechanisms and heals past pain.
2. First Opportunity To...	Therapeutic relationship as first time client viewed self as whole person, as worthwhile, loveable, and valuable individuals; first chance to recognize and examine many issues.
3. Healing Through Interaction	Client's own issues surface in the therapeutic relationship and are able to be worked through; client learns to resolve issues in relationship with therapist and then generalizes this learning to other interactions.
4. Therapist Being a Role-model	Therapist acts as role-model for client; modelled parenting, self-acceptance, appropriate boundaries, safe expression of feelings, healthy self-care, and valuing of self.
5. Therapist Being a Guide	Therapist facilitates process, deepens experience, fosters empowerment, generates insight, and connects client with self. Therapist provides direction, reframes issues, invites exploration, tracks progress, and focuses sessions.

V. Rewards of the Experience

1. Cherished Relationship	Relationship is seen as cherished. A sense of realness and human connectedness; therapist likes client; therapist and client complemented each other. Relationship seen as unique; therapist remained professionally available to client after closure.
2. Client Healing	Client grows in many ways: develops understanding about the past; reconnects to self; regains control over life; reconnects to community.
3. Therapist Growth	Therapist seen as growing both personally and professionally through the relationship. Therapist growth a function of learning over time, gaining experience, and exploring personal values and beliefs.